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Decision-making processes and experiences of older people using the Beating the Blues computerised cognitive behavioural self-help programme: A qualitative study

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TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

Tables

Figures

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ABSTRACT

Introduction: Current recommendations by National Institute of Clinical Excellence (Technology Appraisal 51) emphasise the need for future research to examine the effectiveness of CCBT across the age span. Kaltenthaler *et al.* (2008) recommended future research focuses on acceptability of CCBT through using 'survey and intensive qualitative methods, include the process of initial engagement, continuation versus drop-out, and in those completing, satisfaction or regret undertaking CCBT' (p.1528). The pilot study by McMurchie (2011) was the first to explore the acceptability and effectiveness of the CCBT package Beating the Blues (BTB) solely with older people. Using qualitative methodology, the aim of the current study was to explore the experiences of older people who, when participating in the pilot study chose to use BTB compared to those who chose to remain with their treatment as usual (TAU). The current study aimed to gain a deeper understanding of the acceptability of BTB as well as factors that influence decision-making in terms of uptake to BTB and discontinuation from BTB.

Method: Individual semi-structured interviews were carried out with 20 older people who took part in the pilot study (McMurchie, 2011). Participants were in one of three groups, these were: BTB-completers, BTB-discontinuers and TAU. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA) (Smith *et al.*, 2009).

Findings: Five master themes emerged from the interviews: Beating the Blues as a Process of Change; Relevance of Beating the Blues to Older People; Challenges of Using Beating the Blues; Motivation to Try Something New and Barriers to Beating the Blues at Time of Uptake.

Conclusions: Overall, the master themes reflected the experiences of either "regaining control" or a sense of "hopelessness" when opting whether or not to use BTB in the first instance and to then continue with the treatment. Experiences of using BTB appeared to be linked to the outlook participants had about using a novel treatment with either a sense of hope or impending failure. Participants who chose BTB had a more positive outlook which impacted their ability to manage perceived challenges and work towards recovery. The sense of impending failure seemed to be linked to participants perceiving more barriers to using BTB and struggling to overcome these challenges, resulting in them either declining BTB or feeling they were not benefiting from BTB and therefore discontinuing it.

CHAPTER 1 - INTRODUCTION

1.1 CONTEXT

1.1.1 Changing Demographics of the Population

The world is experiencing a profound demographic shift with a rise in the ageing population. Since 1985, there has been a two per cent increase in the population of older people[1] aged 65 years and over in the United Kingdom (Office for National Statistics (ONS), 2011). This translates to an increase of 1.7 million people. The UK has also seen a decrease in the population aged 16 years and younger. This trend is projected to continue and by 2035, it is predicted that 23 per cent of the UK population will be aged 65 years and over compared to 18 per cent aged 16 years and younger (ONS, 2011). Furthermore, there has also been a disproportionate increase in the population of 'oldest old' (i.e. those aged 85 years and over). Over the last 25 years, the numbers of oldest old have more than doubled, rising from a population of 690,000 in 1985 to 1.4 million in 2010 (ONS, 2011). These numbers are predicted to continue rising, with the population of oldest old in 2035 projected to reach 3.6 million which will account for 5 per cent of the total population (ONS, 2011). Table 1.1 summarises population percentages categorised according to age in the UK in 1985 and 2010 and projections for 2035.

[1] 'Older people' for the remainder of the study refers to individuals aged 65 years and over unless specified otherwise.

Table 1.1 Population by age in the UK in 1985, 2010 and 2035

	YEAR		
Age (Years)	1985	2010	2035
Under 16	21	19	18
16 – 64	64	65	59
65 – 84	14	14	18
85 and over	1	2	5

Source: Office for National Statistics (2011)

Population ageing is not limited to the UK, but is a global demographic trend and in fact, the UK is no longer amongst the fastest growing ageing populations. One reason for this is that despite the UK population having high life expectancy, it has relatively high fertility rates compared to other countries in Europe, for example, Germany and Italy (ONS, 2011). According to figures from Eurostat (2011), the UK ranks as the 15th most aged population in Europe. Outside of Europe, the world's most aged country is Japan where 23 per cent of its population are aged 65 years or over whereas Africa is the least aged region. Figures from more developed countries such as Canada, Australia, New Zealand and the USA show they are less aged than many of the European countries (ONS, 2011).

In light of the demographic shift and the ageing society we now live in, it is reasonable to expect an increasing demand for psychological services and treatments for older people experiencing psychological problems, such as depression and anxiety (Knight *et al.*, 2009; Laidlaw & Panchana, 2009). Therefore, the availability of psychological services for older people will inevitably need to be

increased. The beginning of the aging of the 'baby boomer'[2] cohort from 2011 may mark a greater delivery of mental health services and higher expectations of mental health care (Laidlaw & Baikie, 2007; Laidlaw & Panchana, 2009). Furthermore, given the largest population increase has been amongst the oldest-old population, higher numbers of nonagenarian and centenarian[3] individuals, a population group that mental health professionals most likely have limited experience and knowledge working with, may be accessing mental health services (Laidlaw & Panchana, 2009; Laidlaw, in press). Therefore, there are increasing pressures on mental health professionals to develop greater awareness and understanding of gerontology in order to work effectively with older people (Knight *et al.*, 2009; Laidlaw & Panchana, 2009), and to adapt psychotherapy models to fit with the needs of the oldest-old population (Laidlaw, in press).

1.1.2 Prevalence Rates of Depression and Anxiety in Older People

In the United Kingdom, the Department of Health, Scottish Executive and National Assembly for Wales commissioned two Household Psychiatric Morbidity Surveys to assess the prevalence rates of psychiatric conditions in adults aged 16 and over living in private households (McManus *et al.*, 2009; Singleton *et al.*, 2001). The Clinical Interview Schedule – Revised (CIS-R) (Lewis & Pelosi, 1990; Lewis *et al.*, 1992) was used to establish an ICD-10 diagnosis. Both surveys found that the most prevalent psychiatric condition, across the age span, was mixed anxiety and

[2] 'Baby boomer' refers to individuals born in the years following World War Two where many nations witnessed a significant rise in birth rates.

[3] 'Nonagenarian' refers to individuals aged 90 to 99 years old; 'Centenarian' refers to individuals aged 100 years and over.

depression. The earlier survey reported prevalence rates for mixed anxiety and depression to be nine per cent for 16 to 64 year olds, six per cent for 65 to 69 year olds and 5.5 per cent for 70 to 74 year olds (Singleton *et al.*, 2001). The more recent survey reported prevalence rates for the same condition to be 9.7 per cent, 6.4 per cent and 5.9 per cent respectively for the same age groups (McManus *et al.*, 2009). Both surveys found that older people had the lowest prevalence rates for all psychiatric conditions. A comparable survey conducted in the USA, which used the WHO Composite International Diagnostic Interview (CIDI) (Kessler & Üstün, 2004) to establish DSM-IV diagnosis of major depressive disorder, demonstrated similar prevalence rates for anxiety and depression with lower prevalence rates in older people compared to younger adults (Kessler *et al.*, 2010).

The surveys described above only included individuals who lived in private households, therefore, excluding older people living in nursing homes where significantly higher prevalence rates of anxiety and depression have been reported (Gaboda *et al.*, 2011; Jongenelis *et al.*, 2004). Jongenelis *et al.* (2003) conducted a review of the literature and found prevalence rates for major depressive disorder ranging from six to 26 per cent, minor depression ranging from 11 to 50 per cent and sub-threshold depressive symptoms ranging from 30 to 48 per cent. These results suggest that the figures reported in the household surveys described above may be an underestimation of the true prevalence rates of anxiety and depression in the older people population (Jongenelis *et al.*, 2003).

There is often a misconception that depression is an inevitable or understandable consequence of ageing. However, recent research has debunked this 'myth' through demonstrating that as people age their emotional well-being can actually improve (Carstensen *et al.*, 2000; Riediger *et al.*, 2009). This view of preserved emotional well-being is also discussed by Staudinger (2000) in the 'well-being paradox' whereby older people maintain greater life appreciation and emotional well-being compared to younger adults despite the challenges that may arise in old age. Carstensen *et al.* (2011) say this finding 'flies in the face of stereotypes of aging...that it is often met with disbelief' (p. 21) where younger people continue to view old age 'as a time of sadness and loss' (p. 21). Carstensen (2006) proposed the life-span theory, socio-emotional selectivity theory (SST) to explain this preserved well-being. A theory of motivation, SST states that through aging, time horizons shorten which results in emotional goals being prioritised. Therefore, older people are more likely to invest in what they consider to be most important, like meaningful relationships, and thus gain higher levels of appreciation (Carstensen *et al.*, 2011). This model is one amongst a few developed to explain the fact that older people may be more able to manage the psychological challenges they encounter compared to younger adults.

Despite the preserved emotional well-being demonstrated by older people, clinically relevant symptoms of depression remain to be a common psychological problem in older people. In light of the changing demographics of the population, with the numbers of older people increasing rapidly and assuming the prevalence rates described above continue, the number of older people experiencing psychological

distress is likely to increase. Furthermore, it is thought that the experience of late life depression and anxiety can have serious consequences to their well-being (Fiske *et al.*, 2009).

1.1.3 Impact of Depression and Anxiety in Older People

Late life depression and anxiety can have a damaging effect on older peoples' functioning and quality of life (Van der Weele, 2009). Late life depression has also been associated with increased mortality (Van der Weele, 2009; Vinkers *et al.*, 2004). Depression in older people can increase the risk of suicide. There are, however, differences in the research regarding prevalence of suicide rates in older people. Suicide rates amongst older people are reported to be higher than any other age group (Conwell *et al.*, 2002; O'Connell *et al.*, 2004). However, research has demonstrated figures in the UK that report the highest rates of suicide are seen in adult males between the ages of 25 to 34 years (Shah & Coupe, 2009). Research has indicated the increased risk of suicide amongst depressed older people if suitable treatments are not provided (Hawton & van Heerengen, 2009; Wikorsson *et al.*, 2009).

The General Lifestyle Survey (ONS, 2009) reported that 58 per cent of older people aged 65 to 74 years and 66 percent of older people aged 75 years and over suffer from one or more longstanding physical health conditions, for example, stroke, coronary heart disease and osteoarthritis. The Department of Health (DoH, 2006) reported that stroke is the greatest cause of disability in the UK. Furthermore,

figures have estimated that approximately 75 per cent of strokes occur in older people aged 65 years and over (Michael & Shaughnessy, 2006). Emotional disorders, including depression and anxiety, following stroke are common and can have a detrimental effect on outcome (House *et al.*, 2001). Studies have demonstrated that individuals with post-stroke depression show slower recovery, reduced quality of life, cognitive and functional impairment and increased mortality compared to those who did not develop post-stroke depression (Kauganen *et al.*, 1999; Samakouri *et al.*, 2011; Williams *et al.*, 2004). Similarly to stroke, there has been strong evidence of the presence of depression in patients with coronary heart disease (CHD) and its effect on the increased risk of mortality (Lichtman *et al.*, 2008). The prevalence of osteoarthritis in joint sites (e.g. knee and elbow) is seen to increase with age (Royal College of Physicians, 2008). Studies have demonstrated a strong association between osteoarthritis and depression (Sale *et al.*, 2008) and the presence of depression has been demonstrated to result in increased reports of pain and disability (Kim *et al.*, 2011; Lin *et al.*, 2003; Peat *et al.*, 2000).

The General Lifestyle Survey (ONS, 2009) also reported that older people had a higher number of GP consultations, attended a greater number of outpatient hospital appointments and were admitted more frequently as an inpatient to general hospital than younger people and were inpatients for longer durations. Evidence has shown that the interaction of depression and anxiety with physical health conditions impacts treatment adherence and hospital admissions which can place additional pressure on health care services and can have significant financial implications (Hosaka *et al.*, 1999). Furthermore, Katon *et al.* (2003) demonstrated that late life depression is

associated with considerably higher medical costs. Another point to consider is the role of caregivers, 30 per cent of whom are likely to be aged 65 years and over (US Department of Health & Human Services, 2001). Chronic illness is predominately the 'problem' area that caregivers provide support for at a proportion of approximately 40 per cent in addition to caring for age-related problems including dementia, physical disability, neurological, mental and emotional problems (US Department of Health & Human Services, 2001). Studies have demonstrated that caregivers experience significantly higher levels stress, depression, and burden (Brodaty, 2002; McCann *et al.*, 2004), impaired physical health (Vitaliano *et al.*, 2003) lower levels of life satisfaction and social isolation (Thompson *et al.*, 1993). Such factors may cause caregiver burnout and will likely impact the level of care recipients receive which could potentially lead to care-giving arrangements dissolving prematurely and the recipient being institutionalised (Kasuya *et al.*, 2000), which ultimately is more costly. There is therefore a need to ensure that caregivers are provided adequate support and opportunity for interventions to help improve their quality of life and help care recipients remain in their own homes for as long as possible (Brodaty & Berman, 2008).

1.1.4 Conclusion

The above section highlights the evidence suggesting the world is experiencing a demographic shift towards an aging population with an exponential rise in the numbers of 'oldest old' (ONS, 2011). The potential challenges people may face when aging include impaired physical health, bereavements and multiple losses and reduced independence. Furthermore, it is suggested that as people age, the risk of

developing chronic physical health problems increases (General Lifestyle Survey, 2009). Such challenges may increase the risk of older people developing emotional disorders like anxiety and depression. However, difficulties with anxiety and depression are not an inevitable consequence of aging (Laidlaw & Panchana, 2009). Models of aging have been developed to demonstrate that contrary to the negative age stereotypes held by society, as people age their emotional well-being can improve (Carstensen *et al.*, 2011), an effect also known as 'successful aging' (Woods, 2008). Nevertheless, there is a prevalence of late life anxiety and depression that is clinically significant. Moreover evidence shows that late life emotional disorders impacts on an individual's ability to cope with physical ill health, and is associated with higher use of healthcare services and increased mortality. Therefore, it can be concluded that older people would benefit from treatment, including psychological inventions like cognitive behavioural therapy (CBT). However, of concerning importance is that depression and anxiety in the elderly continues to be under-recognised and under-treated (Barry *et al.*, 2012; Djernes, 2006) despite it having a significant impact on their emotional and physical well-being.

1.2 COGNITIVE BEHAVIOURAL THERAPY (CBT) FOR DEPRESSION AND ANXIETY IN OLDER PEOPLE

The information summarised above highlights the need for effective treatment for late life depression and anxiety. Cuijpers and colleagues (2009) point out that the evidence for the psychological treatment of depression and anxiety in older people is comparatively less than it is for adults of working age. There are certain 'myths'

about older people and psychological treatment (Laidlaw *et al.*, 2003) that may create barriers to them accessing and/or receiving psychological treatments. Such myths include assuming that psychological treatment will be ineffective with older people and that older people do not want psychological treatment. However, several studies have challenged these 'myths' through evidencing that psychological interventions are equally effective with older people as they are with adults of working age (Cuijpers *et al.*, 2006; Serfaty *et al.*, 2009; Wilson *et al.*, 2008) and that given the choice, older people prefer to receive psychological treatment over pharmacological treatment (Arean *et al.*, 2001; Landreville *et al.*, 2001). Furthermore, research has demonstrated that psychological interventions produce better long-term benefits compared to pharmacological treatments in both adults of working age and older adults (Bortollotti *et al.*, 2008; DeRubesis *et al.*, 1999).

There is paucity in the empirical research exploring the effectiveness of psychological treatments with older people, particularly with individuals from the oldest old age category (Cuijpers *et al.*, 2009). However, there have been a number of reviews examining psychological treatments, including CBT, for late life depression. A brief summary of these reviews and their main findings is provided in Table 1.2.

Table 1.2 Summary of reviews examining psychological treatments for late life depression.

Study	Main Findings
Scogin & McElreath, 1994	Meta-analysis of 17 studies. Psychological treatments are more effective than waiting list or placebo control conditions. Effect sizes are comparable to those found with younger adults. Results indicate no superiority of one treatment over another due to small number of studies with older people.
Koder *et al.*, 1996	Meta-analysis 7 studies. Cognitive therapy (CT) is more effective than no treatment or placebo control. Lack of studies of sufficient quality to reliably compare the efficacy of CT over other forms of psychotherapy. Further consideration of how CT should be modified to include age-specific issues.
Engels & Verney, 1997	Meta-analysis of 17 studies. Individual psychological treatments are more effective than group treatments. CT and behavioural therapy (BT) produce largest effects.
McCusker *et al.*, 1998	Review of 40 studies. Psychological treatments and pharmacological treatments are more effective than no treatment and placebo controls.
Cuijpers, 1998	Meta-analysis of 14 studies. Psychological interventions are effective. Effect sizes are comparable to those found with younger adults.
Gatz *et al.*, 1998	Review of 13 studies. Concluded that CBT is a potentially effective treatment for depression and anxiety. Tentative conclusion reached due to lack of evidence-base.
Gerson *et al.*, 1999	Meta-analysis of 45 studies. Psychological and pharmacological treatments appear equally efficacious.
Laidlaw, 2001	Review of 8 studies (including 5 meta-analyses). CBT is an effective psychological treatment. No evidence suggesting need to adapt CBT for older people without cognitive impairment or frailty.
Pinquart & Sorensen, 2001	Meta-analysis of 122 studies. CBT and psychodynamic interventions are effective. Individual therapy more effective than group therapy.
Scogin *et al.*, 2005	Review of 20 studies. Concluded that psychological interventions are beneficial and have a good evidence-base. Further research with 'older' older people (75+ years) is required in addition to exploring the combination of psychotherapy with pharmacotherapy.
Cuijpers *et al.*, 2006	Meta-analysis of 25 studies. Psychological treatment is effective with older people. Effect sizes are comparable to those found with younger adults.
Pinquart *et al.*, 2006	Meta-analysis of 89 studies. Both psychological and pharmacological treatments are effective. Psychotherapy shown to be more effective in older people with mild depression or dysthymia. Further RCTs comparing psychotherapy, pharmacotherapy and control conditions are required.
Pinquart *et al.*, 2007	Meta-analysis of 57 studies. Concluded that CBT and reminiscence show strongest effects and have good evidence-base. Older people with physical and cognitive impairment may benefit from modifications to treatment format and content.
Wilson *et al.*, 2008	Meta-analysis of 12 studies. Despite small number of studies, CBT is more effective than control conditions. Cannot conclude if CBT is superior to other treatment. Need for good-quality RCTs.
Cuijpers *et al.*, 2009	Meta-regression analysis of 112 studies (20 aimed at older adults). Psychotherapies equally effective for older adults and younger adults. Lack of research with older people, particularly with severe depression and in the older old age category.
Samad *et al.*, 2011	Meta-analysis of 4 RCTs. BT is more effective that waiting list control and has comparable effectiveness to other psychotherapies (CT and brief psycho-dynamic therapy).
Krishna *et al.*, 2011	Review of 6 RCTs of group CBT. Concluded that group CBT is an effective treatment compared to waiting list control, benefits were maintained at follow-up. Cannot conclude if the benefits of group psychotherapy are comparable to other active interventions.

In summary, the above reviews demonstrate that psychological treatment is an effective treatment for depression in older people. The reviews suggest that CBT is the most evaluated psychotherapy model with older people and has demonstrated to be an efficacious treatment. The majority of the reviews included studies of varying quality and highlighted that further good-quality randomised controlled trials (RCTs) examining the effectiveness of psychological interventions compared to pharmacotherapy and control conditions is necessary. Furthermore, there are few good-quality comparative studies of psychological interventions for late-life depression. The available research including sufficient numbers of individuals from the older old age categories (75 years and over) is sparse, and increased efforts to recruit these individuals in future research is warranted.

It appears that research examining the effectiveness of psychological interventions in the treatment of anxiety in older people is sparser (Ayers *et al.*, 2007). In their systematic review of 17 studies, Ayers and colleagues (2007) identified four evidence-based treatments for late-life anxiety, including relaxation training, CBT, supportive therapy and CT. Ayers *et al.* (2007) concluded that CBT had the strongest evidence-base, followed by relaxation training. A later review and meta-analysis of seven studies by Hendricks *et al.* (2008) concluded that CBT is an effective treatment for late-life anxiety disorders. The longer-term benefits of CBT could not be commented on as follow-up data was scarce and therefore not included in the analysis (Ayers *et al.*, 2007). Furthermore, as with studies examining late-life depression, individuals in the oldest old age category were under-represented (Hendricks *et al.*, 2008).

1.2.1 Development and Review of CBT for Older People

The previous section highlighted that CBT has the strongest evidence-base as a psychological treatment of late life depression and anxiety. CBT was first developed by Beck in 1976 as a cognitive model of emotional disorders. In its simplest form, the model proposes that an individual's emotions and behaviours are influenced by the way they perceive the world, which in turn is influenced by their underlying assumptions and core beliefs derived from early experiences (Beck *et al.*, 1979). A more detailed description of the CBT model can be found in Beck (1976).

As a treatment, CBT is present-focused, collaborative, structured, time-limited and goal orientated. The aim of CBT is to help individuals identify dysfunctional thinking and behavioural patterns to facilitate symptom reduction. The individual completes thought diaries that challenge the notion that their negative thought patterns are facts but in reality are opinions. This allows the individual to enter a process of reality-testing to challenge these opinions with the aim of forming more realistic and balanced thoughts and adaptive behaviour patterns. There is a large evidence-base for the use of CBT as an effective psychological intervention for various emotional disorders, including depression and anxiety (Beck *et al.*, 1979; Hawton *et al.*, 1989; Wells, 1997). Detailed descriptions of CBT as a treatment for depression are described in Beck *et al.* (1979) and in Wells (1997) for anxiety.

The CBT model has also been applied to different populations, including older people (Laidlaw *et al.*, 2003). While outcome research has demonstrated that unmodified CBT is efficacious for older people (Gatz *et al.*, 1998; Laidlaw, 2001),

there has been speculation that the inclusion of age-specific factors (e.g. psychological adjustment to age-related transitions) would be beneficial (Koder *et al.*, 1996). Laidlaw and colleagues (2004) provided a comprehensive contextualisation conceptualisation framework (CCF) for CBT with older people. In doing this, the authors aimed to 'incorporate age-related differences within a standard CBT framework using a comprehensive conceptualisation framework for older people' (p. 391). The CCF for CBT with older people (Laidlaw *et al.*, 2004) provides therapists, particularly those inexperienced in working with older people, a way of framing or contextualising older people's problems within the standard model of CBT proposed by Beck (1976). The additional age-specific elements incorporated within the CBT model were: *cohort beliefs, transitions in role investments, intergenerational linkages, socio-cultural context and health condition(s)*. Each element serves to broaden the understanding that a therapist will draw on when working with older people in therapy. A detailed description and diagram of this model can be found in the Laidlaw *et al*. (2004) paper (p. 392). Further considerations regarding how CBT may be different with older people is also discussed by Laidlaw and McAlpine (2008) and Laidlaw and Thompson (2008).

Laidlaw and colleagues (2008) conducted the first UK RCT comparing the non-modified CBT to treatment as usual (TAU), which mainly consisted of pharmacotherapy. A total of 40 participants were randomly allocated to receive either CBT or TAU. At the end of treatment, participants in both conditions showed statistically significant improvements on outcome measures for depression, functioning and quality of life, which was maintained at six month follow-up

(Laidlaw *et al.*, 2008). In terms of clinically significant change, results favoured CBT over TAU at end of treatment and three month follow-up (Laidlaw *et al.*, 2008).

A more recent RCT by Serfaty *et al.* (2009) compared the effectiveness of CBT for late life depression against TAU alone and TAU plus talking control, not including specific therapeutic techniques. A total of 204 participants were randomly allocated and completed outcome measures on depression, anxiety, social functioning and quality of life. Results demonstrated that participants receiving CBT showed significant improvement in their symptoms of depression by the end of treatment and also at 10-month follow-up. Both studies, especially the latter, demonstrated the effectiveness of a non-modified version of CBT in treating late-life depression.

In summary, psychological treatments, especially CBT, have shown to be an effective treatment for late-life depression and anxiety. Nevertheless, despite this growing evidence-base, late-life depression and anxiety continues to be undertreated (Barry *et al.*, 2012).

1.2.2 Overview of Policies and Legislation

1.2.2.1 Equality Legislation

The existence of ageism in mental health is acknowledged and was highlighted in the paper by the Royal College of Psychiatry (RCPsych) published in 2009. The paper discusses the discrimination suffered by older people in mental health services, highlighting the importance of services changing to meet the need of the increasing population of older people (RCPsych, 2009). In 2010, the Government Equalities

Office (GEO) produced the *Equality Act 2010: Banning age discrimination in services, public functions and associations*. The Act intends to eliminate unjustifiable age discrimination, including indirect discrimination and positive action, to provide equal opportunities for people aged 18 years and over (GEO, 2010). The Act has major implications in the provision of health and social care services that target specific age groups or have age cut-offs, whereby, without justification to retain these age-based differentiations such services will have to change. The Act therefore suggests altering services to be needs-based as opposed to age-based as recommended by RCPsych (2009).

1.2.2.2 Scottish Policies

Over the recent years the Scottish Government set objectives to review the current availability of psychological therapies and recommendations on the most effective ways to deliver psychological therapies to various populations with a view of outlining the future direction of psychological service provision in Scotland. In response to these objectives, two reports have been produced. These are:

- *Applied Psychologists and Psychology in NHS Scotland: Working Group Discussion Paper* (2010);
- *The Challenge of Delivering Psychological Therapies for Older People in Scotland: Report of Older People's Psychological Therapies Working Group* (2011).

Both of these reports have implications for the development and delivery of psychological services for older people in Scotland.

1.2.2.2.1 Applied Psychologists and Psychology in NHS Scotland: Working Group Discussion Paper

This report reviews the current availability of psychological services in Scotland with the aim of projecting future demand, availability and training issues in psychological services in order to contribute to developing an understanding of the best way towards the health and well-being of the Scottish population (Wells *et al.*, 2010). With regards to older people services, the report identified these services as being severely under-resourced. The report states that in 2010 there were 32.2 whole time equivalent (wte) applied psychologists in older people services, which equates to being less than 20 per cent of the estimated required number of applied psychologists to deliver psychological therapies to the older people population (Wells *et al.*, 2010). This figure has not increased significantly, with only 33.3 wte applied psychologists in post in March 2012 (ISD, 2012). It should be noted that the under-resourced state of psychological service provision was not limited to older people services and is seen across the board; however, the older people services were amongst those considered to require urgent expansion (Wells *et al.*, 2010). In light of this, the report suggests implementing a model of matched care that has five levels; each level has a defined set of problems and associated level of service provision. Higher levels in the model represent presenting problems that are higher in severity and/or complexity and/or chronicity and increases in these results in transition through the levels (Wells *et al.*, 2010). The report proposes the model of matched care can provide some support for the increasing demand in psychological therapies despite limited resources through placing individuals at the appropriate level that meets their needs. For example, individuals who present with mild presenting problems initially receive a form of self-help, group psychotherapies, or brief psychological therapy.

Furthermore, through doing this, it allows for higher-intensity psychological therapies to be reserved for more complex and chronic cases (Wells *et al.*, 2010).

1.2.2.2.2 The Challenge of Delivering Psychological Therapies for Older People in Scotland: Report of Older People's Psychological Therapies Working Group (OPPTWG)

The recent stakeholders report produced as part of the OPPTWG response to the objectives set by the Scottish Government to provide recommendations on the most effective ways to deliver psychological therapies to older people, discusses the importance of delivering evidence based psychological therapies to older people where their psychological needs are understood and met. As highlighted in the Scottish Government report '*Applied Psychologists and Psychology in NHS Scotland*' (Wells *et al.*, 2010), the older peoples' psychological therapies service is identified as being severely under resourced. The OPPTWG therefore discuss their strategic vision of improving access to psychological therapies for older people being split into seven basic principles, including adapting a model of matched care to suit the needs to older people and providing access for older people to general adult services that appropriately meet their needs (OPPTWG, 2011).

The OPPTWG discuss how a matched care model can be adapted to meet the needs of the older people population. There is evidence-based low-intensity interventions utilised in adult psychological therapies services including, self-help materials, guided self-help (GSH) and computerised cognitive behavioural therapy (CCBT). The OPPTWG report discussed how these modes of psychotherapy could be extended to the older people population fitting within the first two tiers of the

matched-care model to increase accessibility. To do this, the OPPTWG suggest adapting self-help materials, GSH approaches and CCBT so that they are age-appropriate and more suited to the needs of older people (OPPTWG, 2011).

In light of the equality legislation (GEO, 2010), the OPPTWG state that inconsistencies in current practices in older people's services need to be addressed, including allowing older people proper access to general adult services. For example, current practice allows individuals under the age of 65 years (the cut-off age for older people) who present with "old age" needs to access older people's services (OPPTWG, 2011). The OPPTWG propose that the reverse should occur for older people who present with needs that could be met by general adult services. This ensures that older people have access to psychological services based on their needs rather than their age (OPPTWG, 2011).

1.2.2.3 Improving Access to Psychological Therapies (IAPT) for older people

Increasing Access to Psychological Therapies (IAPT) services were created in England and Wales for adults aged 16 years and over. However, over the last few years work has been ongoing to improve access to these services for older people (IAPT, 2009). This work has included understanding the needs of older people, removing barriers to access and working on engaging older people with services (IAPT, 2009). In spite these initiatives, older people continue to be under-

represented and account for only four per cent of individuals treated within IAPT (Clark *et al.*, 2009; DOH, 2011).

1.2.3 Conclusion

The above section discusses the effectiveness of CBT as a treatment for late life depression and anxiety. However, despite the growing evidence-base demonstrating this as well as nation-wide initiatives to increase access to psychological therapies (DOH, 2011), late-life depression and anxiety continues to be undertreated (Barry *et al.*, 2012) and policies show that older people are under-represented in psychological services (DOH, 2011). Reasons for this under-representation are varied and one discussed earlier is the lack of specialist clinicians working in older people's psychology services (OPPTWG, 2011; Wells *et al.*, 2010). Other contributing factors may include the low referral rates of older people to psychological services by GPs who act as the main referral gatekeepers (Todman *et al.*, 2011). Research has demonstrated that older people underutilise mental health services which is surprising given that older people view psychotherapy to be as effective and acceptable as pharmacotherapy (Laidlaw, in press). Studies have shown that older people would prefer psychotherapy over medication, if given a choice (Arean *et al.*, 2001; Laidlaw, in press), however, they are less likely to be offered this option (Laidlaw, in press).

It is therefore clear that older people are potentially at a significant disadvantage in terms of accessing psychological therapies. Unfortunately, the current economic

climate indicates that increasing the number of specialist clinicians working in older people's service may not be feasible. Therefore, pioneering and alternative methods that increase access to psychological treatments are of vital importance.

1.3 COMPUTERISED COGNITIVE BEHAVIOUR THERAPY (CCBT)

1.3.1 Introduction to CCBT

The previous sections discussed the effectiveness of CBT as a treatment of depression and anxiety in older people. However, given the high demand for psychological therapies combined with under-resourced psychological services, there are several potential barriers to patients accessing this type of treatment. As highlighted in the section 1.1.4 above, this may be a particular concern for older people services as there are comparatively less clinicians with specialist training than in adult services (Wells *et al.*, 2010). Furthermore, face-to-face interventions such as CBT have been described as "labour intensive" (Van Den Berg *et al.*, 2004 p.509) as they tend to require between six to twenty sessions lasting between fifty minutes to an hour. A possible solution to this dilemma is the use of less intensive interventions that do not require or reduce the need of a therapist, delivering CBT to larger numbers of patients, for example, self-help materials, GSH, and CCBT. Such interventions fit within the stepped-care or matched-care models described in the National Institute of Clinical Excellence (NICE, 2009) and Scottish Intercollegiate Guidelines Network (SIGN, 2010) treatment guidelines for depression and the reports by Wells *et al.* (2010) and the OPPTWG (2012).

Guided self-help (GSH) and self-help materials have been shown to be more effective in the treatment of sub-threshold depression in older people than waiting list or placebo control conditions (Floyd *et al.*, 2004; McKendree-Smith *et al.*, 2003; Scogin *et al.*, 1987; van't Veer-Tazelaar *et al.*, 2009). However, until recently (McMurchie, 2011), there has been no research on the effectiveness of CCBT with older people. CCBT has developed in the wake of health care policy insisting on better access to psychological treatment combined with advances in technology and research demonstrating the effectiveness of computer-based treatments (Cavanagh & Shapiro, 2004). Proudfoot and colleagues (2003a) argue that CBT as a short-term, present-focused therapy incorporating psycho-education and its structured approach lends itself well to computer-delivery. Thus, enabling the principles of CBT to be made available to clients without the presence (or with little presence) of the therapist (Van Den Berg *et al.*, 2004). Proudfoot *et al.* (2003a) highlight that simply transferring the principles of CBT to a computer programme does not suffice, and state this is the reason previous computerised therapy programmes have struggled to succeed. They state the inclusion of 'the non-specific factors implicit in the therapeutic relationship that include therapist attention, regard for the patient, empathy for patients' distress, communication of hope for improvement, maintaining patients' motivation and checking patients' understanding of and satisfaction with the therapy process' (p. 279) are crucial in terms of outcome (Proudfoot *et al.*, 2003a).

1.3.2 Reviews of CCBT for Depression and Anxiety

Foroushani and colleagues (2011) conducted a meta-review of the effectiveness of CCBT and internet-based CBT (ICBT) as a treatment of depression, with or without anxiety, in adults. The authors aimed to examine the quality of existing reviews to enable reliable comparisons of the various CCBT and ICBT packages as a treatment of depression. Only reviews published between 2009 and 2011 examining the efficacy of CCBT and ICBT were included. The authors identified a total of 12 papers covering 10 reviews. The packages included in the 12 papers were: *MoodGYM* (Haldane, 2006), *Overcoming Depression on the Internet* (*ODIN*: Clarke *et al.*, 2005), *Colour Your Life* (*CYL*: Riper & Kramer, 2004), *Overcoming Depression* (Whitfield *et al.*, 2006) and *Beating the Blues* (*BTB*: Proudfoot *et al.*, 2003a). A summary of the 10 reviews as described by Foroushani *et al.* (2011) is provided in table 1.3.

Table 1.3 Summary of CCBT reviews included in meta-review (Foroushani *et al.*, 2011)

Authors/ Year	**Results**	**General Conclusions**
Kaltenthaler *et al.*, 2002; 2004a	MoodGYM, ODIN & CYL packages not directly discussed. Overcoming Depression: One study comparing CCBT and TAU, concluded CCBT was not better than TAU. BTB: Three RCTs, one showed some immediate improvement at one-month follow-up, but not at 3 and 6 months. Other e studies indicated improvement continued at follow-up.	CCBT is as effective as therapist-led CBT (TCBT) (poor-moderate quality evidence); CCBT more effective than TAU (limited evidence of poor-moderate quality); CCBT may be as effective as or less effective than TAU; CCBT might reduce therapist time; CCBT could be useful in a stepped-care programme; No study on economic analysis of CCBT is available.
Kaltenthaler *et al.*, 2006; 2008a	CYL package not directly discussed. MoodGYM: One study reporting MoodGYM is effective at reducing symptoms of depression. ODIN: Two studies, one reported ODIN had no significant impact, rather than a moderated effect on people with low level depression, another study observed a reduction in depression scores. Overcoming Depression: No RCT evidence available, one study reported an improvement in depression symptoms. BTB: Three RCTs and one non-comparative study reported BTB is effective.	Some evidence that CCBT is more effective than TAU in treating depression/anxiety; CCBT might reduce therapist time compared to TCBT; There is some evidence to support the effectiveness of CCBT for the treatment of depression; All studies were associated with considerable drop-out rates; Little evidence was presented regarding participants' preferences and the acceptability of the therapy.
Griffiths & Christensen, 2006	ODIN, CYL, Overcoming Depression and BTB packages not directly discussed. MoodGYM: Two studies reported MoodGYM to be effective in reducing symptoms of depression.	Overall conclusion based on different interventions and health problems. Concluded that most interventions reported to be effective in reducing risk factors or improving symptoms, and it was suggested that many of the studies had methodological limitations.
Spek *et al.*, 2007	MoodGYM, ODIN, CYL, Overcoming Depression and BTB packages not directly discussed.	Review is a meta-analysis on treatment of depression and anxiety that indicates moderate to large mean effect size; significant heterogeneity with depression.
Andersoon, 2009	MoodGYM, ODIN, DYL, Overcoming Depression and BTB packages not directly discussed.	Although there are limitations in evidence, internet-based and computer-based treatments seem to be effective in treatment of depression.
Griffiths *et al.*, 2010	MoodGYM, ODIN, DYL, Overcoming Depression and BTB packages not directly discussed.	Six out of eight trails yielded CBT has positive effect on depression. Authors concluded that internet interventions offer promise for use.

Authors/ Year	Results	General Conclusions
García-Lizana & Muñoz-Mayorga, 2010	MoodGYM, ODIN, DYL, Overcoming Depression and BTB packages not directly discussed.	Concluded that there is insufficient evidence for the effectiveness of ICBT use in treatment of depression. However, conclusions are based on various and heterogeneous interventions.
Andrews *et al.*, 2010	MoodGYM, ODIN, DYL, Overcoming Depression and BTB packages not directly discussed.	CCBT is effective and acceptable for treatment of depression and anxiety and is more effective than waiting list control or TAU.
Wade, 2010	Overcoming Depression and BTB packages not directly discussed. MoodGYM: Based on three studies, MoodGYM reported to be effective in reducing symptoms of depression. ODIN: Two studies, one reported to have no significant impact, the other observed statistically significant small effect size in reduction of depression scores. CYL: Based on one study, CYL could improve depressive symptoms.	Review is concerned with different applications of the internet, and it was suggested that the internet has potentials for supporting patients with depression.
Titov, 2011	ODIN, CYL, Overcoming Depression and BTB packages not directly discussed. MoodGYM: Based on one study, having multiple CBT components is associated with better outcome.	There is evidence for the progression in the field of internet-delivered psychotherapy.

Source: Foroushani *et al.* (2011)

The studies included in the meta-review were of varying quality in terms of rigour and scope, there was also variation in terms of the target populations and interventions assessed, with some of the reviews using broader definitions rather than clearly stating 'CCBT' (Foroushani *et al.*, 2011). Furthermore, the reviews varied in terms of target mental health problem, some included depression only, whereas others included mixed depression and anxiety or indistinct categories such as 'mental health problems' (Foroushani *et al.*, 2011). As demonstrated in table 1.3, many of the reviews did not refer to individual packages; therefore it is difficult to make reliable comparisons of the packages (Foroushani *et al.*, 2011). In spite of these limitations, Foroushani and colleagues cautiously concluded that while there is limited evidence demonstrating the effectiveness of three CCBT packages (*MoodGYM, BTB* and *CYL*) as treatments of depression, there is insufficient evidence to demonstrate reliable comparisons between the packages to highlight a preference. The authors state that conducting high-quality comparative studies is an important agenda for future research to demonstrate superior efficacy between the CCBT packages given the difference in cost between them (Foroushani *et al.*, 2011).

The reviews included in the Foroushani *et al.* (2011) study did not explore the acceptability of CCBT packages to patients. As highlighted in the reviews by Kaltenthaler and colleagues (2006; 2008a), CCBT studies reported considerable drop-out rates which may indicate the treatment is unacceptable to patients. In another systematic review, Kaltenthaler *et al.* (2008b) explored the acceptability of CCBT as a treatment of depression to patients. Information on acceptability included recruitment rates, drop-out rates, and completion of questionnaires. A total of 16

studies of CCBT as a treatment of depression were identified. Kaltenthaler *et al.* (2008b) reported that studies provided limited information on patient up-take rates and methods of recruitment. Six out of the 16 studies aimed to gather information on patient acceptability and satisfaction; however, they only provided information supplied by those who completed treatment and not those who dropped-out. Kaltenthaler *et al.* (2008b) concluded that future research should include more detailed information on methods of recruitment, drop-out rates and reasons for this. They also stated that qualitative and survey-based research on the experience of individuals using CCBT is required at various points in the patient care pathway, including 'the process of initial engagement, continuation versus drop-out, and in those completing, satisfaction or regret undertaking CCBT' (p. 1528).

Waller and Gilbody (2009) conducted a systematic review of both quantitative and qualitative studies to assess barriers to the uptake of CCBT as a treatment for depression and anxiety in adults. The review included a total of 36 studies: 26 quantitative, 5 qualitative, and 5 survey-based studies. Qualitative data produced mixed findings in terms of the acceptability of CCBT. Participants who had used CCBT generally reported high satisfaction levels, found the concepts of CCBT easy to understand and were positive about the technology involved (Waller & Gilbody, 2009). However, it was highlighted that the majority of participants who provided detailed feedback had experience in using computers, and that little experience with computers may reduce accessibility (Waller & Gilbody, 2009). Some participants found CCBT to be arduous, condescending or fast-paced, with a general preference for face-to-face therapy over CCBT (Waller & Gilbody, 2009). Two quantitative

studies implied that older people struggled with the technological aspect of CCBT, suggesting that older people were more likely to drop out (Clarke *et al.*, 2005). Older people were also found to take longer to complete sessions, and this was assumed by the authors to be related to lower level of IT skills amongst older people (White *et al.*, 2000). Survey-based studies reported that therapists were generally less positive about CCBT (Whitfield & Williams, 2004; Williams & Garland, 2002) with concerns over effectiveness and beliefs that CCBT should be a supplement to therapy rather than a stand-alone treatment. Therapists also highlighted that they found the interface to be 'cold' (Waller & Gilbody, 2009). Waller and Gilbody conclude that while the efficacy of CCBT has been demonstrated, barriers to uptake remain implying that CCBT is not necessarily an acceptable form of psychotherapy to everyone. Therefore, the place of CCBT within a stepped-care model may be bypassed by individuals who are unlikely to respond to this type of treatment (Waller & Gilbody, 2009).

1.3.3 Treatment Guidelines

1.3.3.1 National Institute of Clinical Excellence (NICE)

The National Institute of Clinical Excellence (NICE) published guidelines (Technology Appraisal 97) on the use of CCBT in the treatment of the common psychological problems of depression, obsessive-compulsive disorder (OCD) and anxiety, including phobias and panic (NICE, 2006). The review included three CCBT packages for the treatment of depression (*Beating the Blues*, *COPE* and *Overcoming Depression*), one for phobias and panic (*FearFighter*) and one for OCD (*OCFighter*, formerly *BTSteps*). The review concluded that *Beating the Blues* (*BTB*)

is a clinically and cost-effective treatment for mild to moderate depression, and *FearFighter* is an effective treatment for phobias (NICE, 2006). The review stated there is insufficient evidence to recommend the use of the other packages as clinically and cost-effective treatments. The guidance recommends that future CCBT research includes randomised controlled trials (RCTs) conducted within GP settings, using intention to treat (ITT) analysis to account for drop-outs. Furthermore, NICE also recommend that research examines the effectiveness of CCBT with patients from older people population and from different ethnic groups (NICE, 2006).

1.3.3.2 Scottish Intercollegiate Guidelines Network (SIGN)

The Scottish Intercollegiate Guidelines Network (SIGN) published guidelines (Guideline 114) on non-pharmaceutical treatments for depression (SIGN, 2010). The guideline reviewed the evidence base for CCBT as a treatment for depression and concluded that Beating the Blues (BTB) and MoodGym were both effective at reducing symptoms of depression (SIGN, 2010). The guideline recommended the use of CCBT within the context of guided self-help as a treatment option for managing symptoms of depression.

However, it is important to note that despite the growing evidence and recommendations of CCBT as a treatment for depression and anxiety, the guidelines also highlight the importance of clinical judgement when assessing the suitability of individuals to psychological interventions. Self-help treatments, like CCBT, are advocated to be used within a matched care model (Wells *et al.*, 2010) and do not

detract from the importance of having adequately trained clinicians to provide psychological interventions. Nevertheless, the current state of mental health services indicate they are under-resourced (Wells *et al.*, 2010) and innovative and alternative methods, like CCBT, may help improve access to psychological therapies.

1.3.4 Review of *Beating the Blues* Outcome Studies

Proudfoot *et al.* (2003a) believe they have developed the first computerised therapy programme that amalgamates both the principles of CBT with the important non-specific therapeutic factors detailed above (see section 1.3.1), *Beating the Blues (BTB).* Given that BTB is recommended in both the NICE and SIGN guidelines as a treatment for depression, the remainder of this section will focus on the BTB CCBT package.

A review of the literature on BTB was conducted. The review identified the evidence base within the literature claiming to demonstrate the effectiveness of BTB, in addition to highlighting gaps in the literature. Studies were initially identified through Ovid Medline (R) from 1946 to July Week 1 2012, EMBASE from 1974 to 2012 July 13, as well as CINAHL, MEDLINE, and PsycINFO databases. The key search terms used included *depression*, *anxiety*, *cognitive behav* therapy AND computer*, and *Beating the Blues*. Results were limited to English language only and reference sections of the identified papers were also examined to yield further papers not identified in the initial search. The search yielded a total of 14 studies, three were randomised controlled trials (RCT), two were pilot studies, eight were pragmatic studies and one was a comparative study. The papers reviewed in this

section are summarised in Table 1.4 and provide information on the study type, participants and sample size, main findings, and methodological strengths and weaknesses.

Table 1.4 Summary and critique of evidence of BTB outcome studies

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Proudfoot *et al.* (2003a) / United Kingdom	Pilot study / Beta test	20 (11 completed all 8 sessions)	Aged between 18 – 75 years. Responded to a newspaper article, have depression and/or anxiety (ill for 2+ years and previously received either psychotherapy and/or medication).	Participant feedback positive – all found it helpful and majority found it easy to use. Findings sufficient to proceed with RCT (Proudfoot *et al.*, 2003b)	Drop-outs clearly described. Use of screening measures. Completion of pre- and post-outcome measures on depression (BDI-II), anxiety (BAI), attributional style (ASQ) and Work & Social Adjustment Scale (WSA).	Sample self-referred. Lack of comparison group. Inclusion/exclusion criteria not described. High drop-out rate (45%). No intention to treat (ITT) analysis. Small sample size, no power calculation reported. Analysis only done on completers. Comments on feedback not qualitatively reported. No mean age or range provided, difficult to determine if results can be generalised to older people.
Proudfoot *et al.* (2003b) / United Kingdom	RCT (BTB vs. TAU)	167 (BTB=89; TAU=78)	Participants scoring >4 on General Health Questionnaire (GHQ-12) and > 12 on Clinical Interview Schedule (CIS-R) included. Inclusion criteria participants aged between 18 – 75 years. Mean age BTB=43.7 (SD=14.7); TAU=45.7 (SD=14.1).	BTB > TAU improvement on measures of depression, anxiety and work & social adjustment. Improvement maintained at 1, 3 and 6 month follow-up.	Method of randomisation described. Had follow-up period. Description of drop outs. Inclusion/exclusion criteria described. Completion of pre- and post-outcome measures - BDI-II, BAI, ASQ and WSA.	Sample size too small to test if duration and severity of illness impacted outcome. Outcome measures are self-reported. No blind assessor. Excluding significant proportion of older people (aged >75 years). Possibility that older people (65 years +) were under-represented. Difficult to determine if results can be generalised to older people.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Proudfoot *et al.* (2004) / United Kingdom	RCT (BTB vs. TAU)	107 (BTB=57; TAU=50) Included N from 2003b: 167+107= 274 (BTB=146; TAU = 128)	Participants scoring >4 on GHQ-12 and > 12 on CIS-R included. Inclusion criteria participants aged between 18 – 75 years. Mean age BTB=43.6 (SD=14.3); TAU=43.4 (SD=13.7).	Replicated findings of 2003b study. BTB group had significantly greater reductions on BDI-II, BAI and WSA. Results independent of medication use, duration or severity of symptoms prior to using BTB. Concluded BTB is an acceptable treatment for depression	Completion of pre- and post-outcome measures - BDI-II, BAI, ASQ and WSA. Inclusion/exclusion criteria described. Method of randomisation described. Stratification of medication and duration of current episode. Had follow-up period (description of losses at follow-up partially provided). Used ITT analysis (but some data missing from both groups). Power calculation reported.	Effect sizes not reported; analysis of clinical significance of findings not provided. Conclusion based on drop-out rates and self-reports on satisfaction (only with completers). Uptake rates of BTB not addressed. Outcome measures are self-reported. Excluding significant proportion of older people (aged >75 years). Possibility that older people (65 years +) were under-represented. Difficult to determine if results can be generalised to older people.
Grime (2004) / United Kingdom	RCT (BTB vs. CC)	48 (BTB=24; CC=24)	Recruited through NHS occupational health department – eligible to participate if had 10+ cumulative days absence due to stress, GHQ-12 score of 4 or more. Mean age BTB=41 (SD=10.83); CC=37 (SD+8.27).	BTB showed statistically significant reductions in depression scores on the Hospital Anxiety & Depression Scale (HADS) and ASQ. Maintained at 1 month follow-up. No significant differences between 2 groups at 3 and 6 month follow-up.	Inclusion/exclusion criteria described. Completion of pre- and post-outcome measures. Method of randomisation described. Description of drop-outs provided. Evaluated rate of uptake and reasons for non-participation. Follow-up period of 1, 3 and 6 months.	No analysis of factors that may influence drop out. No report of effect sizes, no analysis of clinical significance of findings provided. Although stating ITT analysis was employed, this did not happen as discontinuers data was excluded from overall analysis. CC acts as confounding factor. No age range reported but likely absence of older people in sample, difficult to generalise results.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Van Den Berg *et al.* (2004) / United Kingdom	Pragmatic study in CMHT	13	Patients referred to CMHT with depression.	Statistically significant reduction in Clinical Outcome in Routine Evaluation (CORE) scores by end of 8 sessions, not maintained at 6-month follow-up.	Effect sizes reported, but method of calculation not reported. Follow-up period of 6-months. Study conducted in clinical environment/routine practice.	Rate of uptake not evaluated. Exact numbers of participants eligible to participate, approached, recruited, and dropped out is unclear. Small sample size with no comparison group. No standardised measures of depression and anxiety. Age of participants not reported. Difficult to determine if results can be generalised to older people.
Hunt *et al.* (2006) / United Kingdom	Pragmatic study in stepped-care, primary care mental health service	167 initially referred by GP, 54 completed BTB, 81 dropped-out, 32 still using BTB	Patients referred to primary care mental health service with depression.	Significant reduction in scores on measures of depression and social adjustment. Reported positive comments from participants about BTB.	Use of screening pre- and post-outcome measures (BDI, WSA & GHQ). Uptake rates reported.	No comparison group. Inclusion criteria unclear. Method of analysing qualitative data not reported. Discontinuers data excluded from overall analysis – potential for bias in results. No effect sizes reported. Participant characteristics not reported (e.g. age, gender etc). Clinically significant change not reported.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Cavanagh *et al.* (2006) / United Kingdom	Pragmatic study in routine primary and secondary care practices	219	Age range of 17-70 years, mean age 43.6 (SD=11.7), GHQ-12 score of 4 or more.	Statistically significant reductions on CORE and WSA on completion of BTB, maintained at 6-month follow-up.	Inclusion/exclusion criteria described. Completion of pre- and post-outcome measures. Follow-up period of 6-months. Description of drop-outs provided. Effect sizes and method of calculation reported. Used ITT analysis (using LOCF method). Reported percentage of patients meeting both reliable and clinically significant change criteria.	No comparison group. No standardised measures of depression and anxiety. Uptake rates not reported. High losses at follow-up. Subsequent treatment during follow-up not evaluated. No reports on concomitant treatment during study. Use of LOCF method may impact outcomes associated with BTB. Exclusion of significant proportion of older people (70+ years). Difficult to determine if results can be generalised to older people.
Mitchell & Dunn (2007) / United Kingdom	Pragmatic study in higher education	12	Higher education students. Score 14+ on BDI-II. Mean age of 25.58 years.	Statistically significant reduction in symptoms of depression (BDI-II). No significant difference in anxiety score on BAI. Conclude BTB is an effective, credible and acceptable treatment.	Inclusion/exclusion criteria described. Completion of pre-and post-outcome measures (BDI-II & BAI). Uptake rate reported. Description of drop-outs provided. Effect sizes and method of calculation reported. Provided qualitative description of feedback supplied by participants (N=10).	Small sample size. No comparison group. Only included results of completers with post-outcome data (N=8) in analysis. No follow-up data provided due to small numbers (N=4). No ITT analysis used. Qualitative method used to analyse feedback not reported. Mean age implies absence of older people in sample, difficult to determine if results can be generalised to older people.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Learmonth & Rai (2007) / United Kingdom	Pragmatic study BTB vs. WLC in secondary and tertiary mental health services	590 recruited, 3 groups: WLC, N=86 BTB (without physical co-morbidity), N=407 BTB-pc (with physical co-morbidity) N=97.	Patients referred with depression and co-morbid physical health difficulties. Participants in each group matched for age and gender ratio. Age range for overall sample 18 – 70 years.	BTB patients with or without co-morbid physical health difficulties showed greater reductions in symptoms of depression (medium effect sizes).	Comparison group. Use of standardised pre- and post-outcome measure for depression (BDI-II). Effect sizes reported. Use of ITT analysis. Report percentage of participants meeting both reliable and clinically significant change criteria.	No randomisation. Uptake rates not reported. Drop-out rates not clearly reported. ITT method used not reported. Using ITT can potentially impact outcomes associated with BTB. No measure of physical well-being administered. Exclusion of significant proportion of older people (70+ years), therefore difficult to determine if results can be generalised to older people.
Learmonth & Rai (2008) / United Kingdom	Pragmatic study in NHS specialist CBT unit.	104	Patients with chronic depression and anxiety, on waiting list for one-to-one CBT. Age range 19-70, mean age=39 (SD=11.6)	Completers showed statistically significant improvement on CORE.	Exclusion criteria described. Uptake reported (details unclear). Reported problem duration and treatment history. Description of drop-outs provided. Use of ITT analysis with LOCF method. Effect sizes reported (but method of calculation not reported). Reported percentage of patients meeting both reliable and clinically significant change criteria.	No comparison group. No assessment for inclusion/exclusion criteria and no minimum level of symptomatology for inclusion defined. No follow-up period. No standardised measures of depression or anxiety used. Use of LOCF method may impact outcomes associated with BTB. Exclusion of significant proportion of older people (70+ years). Difficult to determine if results can be generalised to older people.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Learmonth *et al.* (2008) / United Kingdom	Pragmatic study in NHS specialist CBT unit	555	Patients referred with depression and anxiety, on waiting list for one-to-one CBT. Age range 17-70, mean age=40 (SD=12)	Completers showed statistically significant reductions in BDI-II and BAI scores. When doing ITT analysis with LOCF method the effect sizes reduced (BDI-II: 0.85 to 0.72; BAI: 0.55 to 0.5). Percentage of participants meeting reliable and clinically significant improvement reduced following ITT analysis (BDI-II: 26% to 21%; BAI: 23% to 19%). 19% of completers referred to one-to-one CBT compared to 90% of non-completers. Mean number of one-to-one sessions after BTB was 3.5, which is significantly less than the average 15 for individuals not accessing BTB.	Inclusion/exclusion criteria described. Reports uptake rate. Completion of pre-and post-outcome measures (BDI-II & BAI). Reported problem duration. Effect sizes (large) and method of calculation reported. Reported percentage of patients meeting both reliable and clinically significant change criteria. Description of drop-outs provided. Used ITT analysis with LOCF method.	No comparison group. No defined follow-up period – varied between 6 – 8 weeks. Use of LOCF method may impact outcomes associated with BTB. Mismatch in number of participants' data for depression and anxiety included in the analysis (BDI-II = 244; BAI=252) and number of participants labelled as completers (N=394). Similarly in ITT analysis (N=555: BDI-II= 298; BAI=301). Lost data not explained clearly, questions the validity of the results. No mention of concurrent psychotropic medication usage. Of the completers who went onto one-to-one treatment, there is no clear indication of when this started, and if it was after completion of follow-up measures. Exclusion of significant proportion of older people (70+ years). Difficult to determine if results can be generalised to older people.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Pittaway *et al.* (2009) / United Kingdom	Comparative clinical feasibility study of 3 self-help CBT tools (BTB vs. overcoming depression / anxiety workbooks vs. Living life to the full website)	100 (180 initially referred); 52 completers; 38 discontinuers; 10 excluded. N=50 used for purpose of analysis.	Patients with mild to moderate depression and/or anxiety referred to secondary mental health services by GPs. Age range from 18–75+ years, modal age range 25-44 years.	Significant difference between completers and non-completers in terms of age (18-24 group significantly less likely to complete treatment than 25-44 group and 45+ group), and in terms of problem duration (>4 years duration more likely to complete). No significant differences on CORE at intake. ANCOVA indicates no significant difference in reduction of scores between 3 tools, all showed significant improvements on CORE scores pre- and post-treatment. No significant association between reduction in CORE scores and number of GP visits or between completers and non-completers.	Inclusion/exclusion criteria described. Follow-up period of 6 months to measure number of GP visits following treatment in both completers and non-completers. Use of pre- and post-outcome measure (CORE). Reported problem duration and psychotropic medication usage. Uptake rates reported. Accounted for effects of concurrent psychotropic medication usage > 6-months and psychotherapy (excluded from analysis). Reported percentage of patients meeting both reliable and clinically significant change criteria.	No control group – all 3 groups receiving intervention. Small overall sample size and especially within each group – may explain lack of statistical difference between groups. No standardised measures for depression or anxiety used. High drop-out rates, not fully explained. No follow-up period to assess outcome. Analysis of outcome only done for completers group. Effect sizes not reported. Exclusion of participants taking medication >6-months, however, positive outcomes may be due to concurrent medication usage regardless of duration. Inclusion of participants with 'pure anxiety' potentially putting BTB at a disadvantage. No mean age reported, modal age range suggests older people population is under-represented. Difficult to determine if results can be generalised to older people.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Ormrod *et al.* (2010) / United Kingdom	Pilot study of outcomes and alliance	23 (16 completed BTB)	Patients referred to adult mental health service with depression and anxiety. Mean age 47 years (SD=11).	Following BTB, there was a significant reduction in depression scores and 56% showed clinically significant improvement. No significant effect on anxiety scores, both statistically and clinically. Therapeutic alliance measured by the ARMS (Agnew-Davies Relationship Measure) tentatively suggests participants form a positive therapeutic relationship with BTB package; however, this relationship is less strong than in 1-2-1 therapy sessions. No relationship found between outcome and alliance demonstrated.	Drop-out rates explained. Use of pre- and post-outcome measures (BDI-II, BAI). Reported percentage of patients meeting both reliable and clinically significant change criteria.	No comparison group. Small sample size, unlikely to meet statistical power (no calculation reported). Inclusion/exclusion criteria not described. No ITT analysis, analysis only done on completers' data. No effect sizes reported.

Author(s) / Country	Method / Study Type	Sample Size (N)	Participants	Main Findings	Strengths	Weaknesses
Cavanagh *et al.* (2011) / United Kingdom	Pragmatic study in service-user led self-help clinic	295 (510 initially referred, 351 suitable for BTB).	Patients referred with depression and/or anxiety (referrals made by various sources, including self). Aged between 16 and 66+ (no overall mean or range provided)	Self-referred individuals (compared to individuals referred by 3rd party) significantly more likely to start BTB, complete at least 2 sessions and all 8 sessions. No significant differences in uptake rates on all measured variables. Symptomatology between completers and discontinuers was significantly lower at point of intake. ITT analysis of participants completing at least 2 sessions of BTB showed statistically significant reductions on all measures. Furthermore, 53.6% of sample no longer met 'caseness' for depression or anxiety after BTB.	Use of pre- and post-outcome measures. Report uptake rates. Drop-out rates described. Use of ITT analysis with LOCF method. Effect sizes (medium to large for outcome data) and method of calculation reported. Reported percentage of participants meeting both reliable and clinically significant (in terms of 'caseness') change criteria.	No inclusion/exclusion criteria described. No comparison group. No follow-up period. Use of LOCF method in ITT analysis, results in underestimation of clinical outcomes. No mention of potential effects of concurrent psychotropic medication usage. Only 2% of sample aged 66+. Significant absence of older people in sample, difficult to determine if results can be generalised to older people.

In summary, the studies above demonstrate the outcome data for BTB, while positive, remains to be relatively poor. The majority of studies have substantial methodological weaknesses, resulting in the outcome data being potentially flawed. Two of the studies have been carried out in populations that are unlikely to represent a true clinical sample (Grime, 2004; Mitchell & Dunn, 2007). Four of the studies were conducted with a very small sample size that brings the validity of the results into question (Mitchell & Dunn, 2007; Omrod *et al.*, 2010; Proudfoot *et al.*, 2003a; Van Den Berg *et al.*, 2004). Furthermore, there were very few participants from the older people population included in the studies, and no participants from the oldest old population were included, thereby making it difficult to determine if the results could be generalised to the older people population.

1.3.5 Review of *Beating the Blues* Process Studies

When reviewing the literature on *BTB*, it became apparent that there is a lack of qualitative research on the *BTB* programme. Using the same search strategy described above with the addition of the term *qualitative* one qualitative study was identified regarding the acceptability of BTB undertaken by Hind *et al.* (2010). This study was conducted as part of a wider pilot study testing the feasibility of undertaking a full trial exploring the use of CCBT as a treatment of depression in people with multiple sclerosis (MS) (Cooper *et al.*, 2011). The qualitative study by Hind *et al.* (2010) explored the acceptability of two CCBT packages (*MoodGym* and *BTB*) for the treatment of depression in people with MS. A total of 17 participants consented to take part in the study. Participants had a median age of 46 years, ranging from 30 to 61 years (no mean age is reported). Participants were allocated

to one of two CCBT packages; *Beating the Blues* (*BTB*) (N=8) or *MoodGym* (N=9), there was no control group. The researchers attempted to balance variables such as gender, MS type and disability level between the two groups.

After completing each session of either CCBT package, participants were asked to complete weekly evaluation sheets regarding their views on the acceptability and appropriateness of the treatment. Participants also completed a brief semi-structured interview over the telephone following their first lesson to ascertain if there were any problems in the utility of the CCBT package. On completion of, or on discontinuation of the intervention, participants completed an in-depth face-to-face interview. The interview covered topics on the patterns of use; likes and dislikes about the intervention; suitability of the treatment for people with MS; if and how they found the intervention beneficial; and any identified problems. The interviews were analysed using 'Framework Analysis' (Ritchie & Spencer, 1994), which is a qualitative method often used in applied policy research. The authors reported including the perspective of a person with MS while conducting the analysis. The analysis demonstrated the occurrence of three key themes, these are: 'the burden of CCBT for people with physical and cognitive morbidity', 'lack of human input' and 'acknowledgement of physical illness'. The latter two key themes had associated sub-themes. For the theme 'lack of human input' these were: 'social isolation', 'problem identification and definition', 'goal setting' and 'failure to distinguish between events, thoughts and beliefs'. For the theme 'acknowledgement of physical illness' these were: 'grieving', 'depression symptom inventories' and 'inappropriate material'. Principles of saturation were applied when conducting the analysis

whereby early identified themes persisted through the majority of subsequent interviews. From the analysis, the authors concluded that CCBT packages created to treat depression require adaptations to better meet the needs of people with chronic physical health conditions.

There are a number of limitations to the above study and so the findings should be treated with a degree of caution. The authors recognise that some of their findings may not be representative of the wider population of people suffering from physical health conditions other than MS, or of people suffering with depression without the presence of co-morbid physical health problems. There was no description of the recruitment process in detail, for example, the authors did not state the reasons why some participants chose not to take part, but only if participants did not meet the inclusion criteria. Allocation to either CCBT package was not done through randomisation. The process of allocating participants and how this was decided was not explained by the authors. The authors did not report the number of sessions participants completed before discontinuing with either package. Furthermore, it appears the authors did not determine participants' level of experience and confidence of using computers. In term of the qualitative methodology, the authors declared using 'Framework Analysis' but did not report their justification for choosing this methodology or what other methodologies they considered. Furthermore, the authors did not report how their study meets the principles established by Yardley (2000, 2008) to assess the quality of qualitative research. However, the authors implied examining the credibility of their findings through having more than one analyst in addition to obtaining the perspective of a person

with MS. However, the exact process by which they did this is not detailed in the article. With regards to the findings of the study, the authors occasionally distinguished which CCBT package (*BTB* vs. *MoodGym*) the findings related to. However, this was inconsistent and it is therefore difficult to determine the acceptability and appropriateness of each individual CCBT package to the study population. Finally, the participants' age ranged from 30 to 61 years which indicates the absence of older people (65 years or over) in the participant group. It is therefore difficult to determine if the results of this study are applicable to the older people population. Nevertheless, this study is the first to qualitatively examine the acceptability of BTB to any population, highlighting a significant gap in the evidence.

1.3.6 Conclusion

The above section highlights that CCBT is an innovative and alternative method of increasing access to psychological therapies. In terms of the CCBT packages available, BTB appears to have the strongest existing evidence-base for the treatment of depression. However, there is no evidence to support the use of BTB over other CCBT packages and further good-quality comparative studies are recommended (Foroushani *et al.*, 2011). Despite this, the NICE guidelines for CCBT as a treatment for depression recommended BTB, stating that it had the strongest evidence-base and there was insufficient evidence for the other CCBT packages considered (NICE, 2006). Outcome studies for BTB have shown that it is an effective treatment for depression in adults compared to waiting list control (WLC) or treatment as usual (TAU). Nevertheless, there continues to be a gap in the

evidence for BTB, including the lack of participants from the older people population and the lack of qualitative research investigating the acceptability and barriers to BTB.

1.4 CCBT AND OLDER PEOPLE

1.4.1 Older People and Computers

There is a widespread opinion that older people would find computer use unacceptable. However, the society we now live in is one that is becoming more reliant on functioning through technology. The internet is acknowledged as an everyday way of communicating (Pew Internet & American Life Project, 2005). Furthermore, the internet has massively increased resources and opportunities for people in distress, including the delivery of online support groups (Meier, 2004), online therapy (Barak, 2004), and health-related information (Cline & Haynes, 2001). The delivery of public services is also thought to improve through the use of internet technology (Cabinet Office, 2005a, 2005b). Older people are considered to be heavy users of public services, for example, health care, housing and social care, but are also regarded as disadvantaged due to lack of access to internet technology (Cabinet Office, 2002). The Office for National Statistics (Randall, 2010) reported that households without internet were more likely to be older people over retirement age. Figures from the UK suggest that internet use amongst older people has increased from 26 per cent to 32 per cent between 2008 and 2010 (ONS, 2010). Nevertheless, these figures are significantly lower compared to the proportion of people under retirement age. This gap has been described as a 'digital divide' (Randall, 2010; p. 3). Similar figures have been demonstrated in surveys conducted

in the United States (Fox & Jones, 2009). However, the figures described above are predicted to change. With the initiation of the 'Baby Boomers' to the over 65 population, a rise of technologically savvy older people is expected over the next decade (Fox, 2006). However, Fox (2006) states that the notion that older people will be the fastest-growing demographic group accessing the internet is misleading as many of them will have been using the internet prior to reaching retirement age (Fox, 2006). Furthermore, there continues to be little evidence of older people in their seventies and eighties joining the online community (Fox, 2006). Perceived barriers to older people accessing internet technology include feeling too old, lack of interest, fear of technology, perceived lack of experience and skills, security concerns, and problems associated with physical health and disability (Morris & Brading, 2007). Despite these barriers, research has demonstrated that computer and internet use appears to contribute towards older people's sense of empowerment and improved well-being (Shapira *et al.*, 2007).

1.4.2 Review of Evidence of CCBT with Older People

The absence of participants aged 65 years or over in the CCBT studies discussed above is especially apparent, despite recommendations from NICE (2006) that future research focuses on the effectiveness of CCBT with people of all ages. Kaltenthaler *et al.* (2004b) acknowledged that older people often present with symptoms of depression 'but for whom computer use may be unacceptable' (p. 73). Speculations of this nature may explain why there is a continued absence of older people in CCBT research to date. A small study carried out by Elsegood and Powell (2008) attempted to challenge the notion that CCBT would be a less acceptable mode of psychotherapy

to older people. Through the use of a self-designed questionnaire consisting of nine multiple-choice questions, the authors aimed to ascertain participants level of interest to use CCBT and if so, their willingness to learn the necessary computer skills (Elsegood & Powell, 2008). Participants were also asked to complete demographic information including age, gender, and previous experience of computers, self-help and psychological therapy. Furthermore, there was an option to make further comments. The questionnaire was sent out to a purposefully selected sample of 60 service users. A total of 38 (63.3 per cent) service users responded. Results indicated that 44.7 per cent of respondents indicated an interest in using CCBT for depression and/or anxiety if available and would be willing to learn the necessary computer skills. Furthermore, of the 38 people who responded, only six people (15.8 per cent) had previous computer experience, indicating that prior experience and confidence in computers is not necessarily a predictor of interest. The results also indicated that individuals who had previously benefitted from self-help were more likely to show interest in CCBT as opposed to individuals who had benefited from one-to-one therapy (Elsegood & Powell, 2008). The authors analysed the responses in the 'further comments' section of the questionnaire using thematic analysis. Common themes noted in the data indicated perceived barriers to using CCBT such as lack of motivation due to depression, fear of technology, concern over poor memory, sensory and/or motor abilities and feeling too old to learn to use a computer. There were also indications of preferring one-to-one therapy to CCBT. In contrast, some of the responses implied an enthusiasm to learn new skills (Eslegood & Powell, 2008).

While the authors may infer from the results that older people are more willing to try CCBT than previously speculated, the results of the study should be viewed with caution. There are several limitations to the study, the main one being the uncertainty in the representativeness of the sample to the wider older people population. The sample of 60 service users was selected by clinicians from the older people's service in which the study was being conducted. It is therefore possible the selected participants may be more open to the idea of CCBT than if participants were selected at random. Furthermore, the sample size selected was small and while no power calculation is reported in the study, it can be assumed that power was not met. Finally, the questionnaire utilised was self-designed and the authors do not report if the questionnaire was piloted initially. Therefore the reliability and validity of the questionnaire is unknown. In fact, the authors discuss participants struggling with certain wording used on the questionnaire which, may have been noticed if it were piloted. Despite these limitations, the above study indicates that assumptions made about older people and computer usage may be unfounded and they may therefore be a population group where CCBT can be utilised.

McMurchie (2011) conducted the first study to investigate the effectiveness and acceptability of the CCBT package, *Beating the Blues* (BTB), with older people who were experiencing depression and anxiety. The study was a patient preference trial examining the acceptability of BTB to older people through determining uptake rates. Participants had the choice of choosing BTB in addition to their treatment as usual (BTB+TAU), or to remain with their treatment as usual (TAU) alone. Treatment as Usual (TAU) is defined as participants continuing to receive their

normal, routine care as long as it did not include receiving a formalised face-to-face psychological treatment from an accredited therapist (McMurchie, 2011). The study therefore had an intervention and control group. The study also explored the potential influence of participant characteristics, for example, age, gender, deprivation category classification, experience and confidence with computers, psychiatric history, duration of current episode of depression, and co-morbid physical health problems on the rate of uptake. In addition to examining rate of uptake, the study also examined drop-out rates from BTB. The BTB programme involved eight hourly sessions over eight weeks. Pre- and post-outcome measures were used to measure clinical symptoms of depression and anxiety. The measures were the Geriatric Depression Scale (GDS), Geriatric Anxiety Inventory (GAI), and the Clinical Outcome in Routine Evaluation (CORE). The aims of the study were:

1. Explore the acceptability of BTB to older people in terms of drop-out rates.
2. Explore whether BTB is effective in treating the symptoms of depression and anxiety in older people. It was hypothesised that individuals receiving BTB would show a greater reduction in their symptoms compared to individuals in the TAU group. Furthermore, it was explored if these gains would be maintained at one-month follow-up.
3. Explore the acceptability of BTB to older people in terms of uptake rates.
4. Explore participant characteristics that may influence their preference to receive BTB or TAU. The researcher hypothesised that individuals who opted to receive BTB would have greater experience and confidence with computers than individuals who opted to remain with their TAU.

The researcher used an Intention-to-Treat (ITT) analysis with the Last Observation Carried Forward (LOCF) method when conducting the statistical analyses to determine the outcome of the two treatment conditions. This meant including data from all individuals who began treatment, whether they completed all 8 sessions or not. The missing data for participants who discontinued from treatment was replaced with the last recorded score on an outcome measure. While this conservative method may result in an underestimation of the clinical outcomes, it prevents the results from being biased through only including the data from individuals who completed the full course of treatment.

Out of a total of 77 individuals approached to participate, a total of 58 (75.3 per cent) participants were recruited. Of the 58 individuals, 38 (65.5 per cent) opted to receive BTB and 20 (34.5 per cent) opted to remain with their TAU. Participants had an overall mean age of 74.43 years (BTB+TAU= 71.58, SD=4.43; TAU= 75.55, SD=6.27), ranging from 65 to 83 years. With regards to differences between the BTB+TAU and TAU groups, there were significant differences in terms of age and self-reported confidence and experience of using a computer. Participants in the BTB+TAU group were significantly younger and had higher self-reported levels of confidence and experience in using computers compared to the TAU group. The two groups did not differ in terms of gender, deprivation category classification, co-morbid physical health problems, use of psychotropic medication, duration of current episode of depression and psychiatric history.

In terms of drop-out rates, a total of 27.3 per cent of participants (N=9) discontinued the BTB treatment prior to completion. The reasons participants provided for discontinuing BTB included: found BTB unhelpful (N=1), difficulty using computer hardware (N=1), offered opportunity to attend face-to-face counselling (N=1), significant deterioration in physical health (N=2), own computer malfunctioned (N=1), felt better and no longer wished to continue (N=1), anxiety made it difficult to concentrate (N=1), and no reason provided (N=1). An additional five participants did not complete one-month follow-up measures, of which, two participants did not complete post-treatment measures. Within the TAU group, a total of four participants dropped-out before completing post-treatment measures, plus an additional two participants dropped-out before completing one-month follow-up measures. Statistical analysis demonstrated no significant difference between the two groups in terms of number of participants dropping out of the study.

With regards to treatment outcome, results indicated that there were no significant differences between the two groups at the time of pre-assessment, indicating that both groups had similar levels of psychopathology as measured by the outcome measures. The results demonstrated a significant reduction on all of the outcome measures in the BTB+TAU group compared to the TAU group. The effect sizes in favour of the BTB+TAU group over TAU at post-treatment assessment were moderate to large, ranging from 0.59 to 0.85 (GDS>CORE>GAI) at post-treatment assessment and ranging from 0.61 to 0.80 (GDS>GAI>CORE) at one-month follow-up. In addition to statistically significant differences, the results also demonstrated a clinically significant improvement on the GDS for participants in the BTB+TAU

group at post-treatment and one-month follow-up assessment points. The BTB+TAU group also showed greater clinical improvements on the GAI and CORE, however, this was not statistically significant.

A major limitation of the study by McMurchie (2011) is that it did not employ a randomised controlled trial (RCT). Therefore, the results of the patient preference trial should be viewed with a degree of caution as participants were not randomly allocated to groups bringing the generalisability of the results into question. Furthermore, there is a potential bias of the results in favour of BTB given the nature of a patient preference trial whereby individuals choosing a treatment may be more likely to find it acceptable and perhaps benefit from it. However, McMurchie (2011) justified the use of a patient preference trial fitting more neatly with the aims of the study in terms of establishing how acceptable the BTB treatment is with an older people population. Furthermore, longer-term follow-ups were not obtained and the study could not conclude on the long-term benefits of BTB as a treatment of depression for older people. McMurchie (2011) discussed the importance of building the evidence-base of BTB in the older people population as an initial step before conducting an RCT with long-term follow-up and suggested considering this study as a pilot study. While the study described a power calculation, it was only able to meet power in the BTB+TAU group and not the TAU group. Despite the relatively small overall number of participants recruited, the study still demonstrated moderate to large effect sizes and post hoc analysis indicated a type II error was avoided. A further limitation includes the use of clinical cut-off scores as part of the inclusion criteria for the study. McMurchie (2011) did not utilise a diagnostic

measure, for example the SCID, to determine the diagnostic categories participants belonged to (e.g. major depressive disorder). Therefore, it is difficult to determine if the results of this study apply to specific diagnostic categories. McMurchie (2011) recognises this as a limitation but states that the use of clinical cut-offs on standardised measures of depression and anxiety is more reflective of typical clinical practice and provides information on symptom reduction. Although the study recruited from the older people population, the mean age of participants were 74.43 years, ranging from 65 to 83 years. Therefore, older people who fall within the 'oldest old' category (85 years and over) were absent from the study population. It is therefore difficult to determine if the results of this study can be generalised to individuals who fall within the oldest old age category. A final limitation in this study is the lack of information regarding patient satisfaction in using the BTB treatment package. McMurchie (2011) proposed the use of qualitative methods, as recommended by Kaltenthaler *et al.* (2008b) to gain further information on patient satisfaction and their overall experience of using the BTB programme. Despite these limitations, McMurchie (2011) concluded this study, which could be regarded as a pilot study, had provided initial evidence demonstrating the effectiveness of BTB of treating symptoms of depression and anxiety in older people.

A recent review by Crabb *et al.* (2012) examined the extent that older people are represented in research of CCBT for depression. Studies published between 2000 and 2010 examining the efficacy of CCBT for depression were identified. Each article was searched for age-related information, including age range, number of older people included in the sample, and data presented on age-related differences in

terms of recruitment, drop-out and outcome (Crabb *et al.*, 2012). A total of 19 studies out of the original 32 identified studies included at least one person over the age of 65 years in their sample. There were no identified studies that exclusively recruited older people. Crabb *et al.* (2012) concluded that the average proportion of older people in the reviewed studies comprised of three per cent. This figure is a significant under-representation of the older people population with depression. No studies presented data on recruitment, drop-out or outcome amongst older people and therefore age-related differences could not be reported (Crabb *et al.*, 2012). Comments provided by authors of the included studies suggested that older people were more likely to experience technical challenges and therefore required an additional level of support in the form of guidance and precise instructions (Crabb *et al.*, 2012). Furthermore, it was also observed that older people experienced the content of the CCBT programmes to be more tailored to the needs of younger adults (Crabb *et al.*, 2012). Factors that may improve the acceptability of CCBT to older people, thereby potentially increasing the numbers of older people participating in CCBT research, included providing a demonstration of the CCBT programme prior to commencing treatment and having easy access to support, both clinical and technical, throughout the duration of the CCBT programme (Crabb *et al.*, 2012).

1.5 SUMMARY AND CONCLUSION

The sections above have highlighted that there has been a profound demographic shift towards an aging population. There is a prevalence of depression and anxiety amongst older people that can have a serious impact on quality of life, physical health and mortality. The need for effective treatments for depression and anxiety is

acknowledged and there is an expectation that demand for treatment will increase amongst the older people population. Psychological treatments like CBT have been shown to be acceptable to older people and are effective at reducing symptoms of depression and anxiety. However, older people's psychology services are under-resourced with comparatively less specialist clinicians working in these services than in adult and child/adolescent services. Therefore, the availability of psychological interventions like CBT, which can be labour-intensive, is limited and the current financial climate means that increasing the number clinicians to improve this may not be feasible. Alternative and pioneering methods to tackle this problem have been created, and one is the use of CCBT. There is a widespread assumption that older people would be unwilling and/or unable to use computers, however, research has demonstrated this is not automatically the case. The evidence for CCBT, and BTB in particular, is strong, however this has mainly been with adults of working age. Recently, a study demonstrated the effectiveness of BTB with older people in reducing symptoms of depression and anxiety. However, there continues to be a lack of qualitative research exploring the acceptability of BTB and there are currently no such studies with older people.

1.6 RATIONALE FOR CURRENT STUDY

No study to date has qualitatively explored the acceptability BTB with older people. Furthermore, there is only one qualitative study exploring the acceptability of BTB to date (Hind *et al.*, 2010). There is therefore little known about the experiences of people using BTB. The current study will therefore address this significant gap in the literature and will be first to qualitatively explore factors influencing older

peoples' decision-making processes in relation to uptake to BTB and discontinuation from BTB as well as the experiences of older people using BTB. The current study will meet the research recommendation outlined by Kaltenthaler *et al.* (2008b) that a greater understanding of the experiences of individuals using CCBT is required at various points in the patient care pathway with consideration of the initial engagement process, differences between those who complete and those who discontinue and overall satisfaction or lack thereof in undertaking CCBT. The current study will have a sample of individuals meeting these criteria whereby it aims to recruit individuals who have been offered BTB comprising of individuals who completed all eight sessions of BTB, individuals who discontinued prior to completion and individuals who declined to undertake it. This design will provide detailed understanding of the factors that influence decision-making in terms of accepting or declining BTB, as well as potential barriers to uptake and factors that influence decision making in terms of discontinuing from BTB. Furthermore, the experiences of individuals who used BTB, both completers and discontinuers will be explored including feelings of satisfaction and/or regret in undertaking BTB.

1.7 AIMS OF CURRENT STUDY

The current study aims to add to the one existing qualitative study in this area by being the first study, to the researcher's knowledge, to explore the lived experiences of older people who used the BTB programme. Furthermore, the current study also aims to explore the factors that influenced older people's decision-making processes in terms of their decision to either use or not use BTB and in those who discontinued BTB, the factors that influenced their decision to stop at the stage that they did.

Through exploring the experiences of using BTB, the current study aims to identify important aspects of this treatment programme which may influence engagement and recovery. The study was designed to follow-on from the recently completed study by McMurchie (2011) described above (see section 1.4.2) whereby it recruited individuals who recently participated in the study by McMurchie (2011) including those who completed BTB, discontinued BTB and declined to use BTB. Given that the current study is qualitative, it is not hypothesis-driven but exploratory. It is anticipated the results will help inform service provision and offer consideration for BTB, or CCBT general, to be readily utilised within older people's psychological therapies services which it currently is not.

CHAPTER 2 - METHODOLOGY

The following chapter outlines the research methodology and main ethical issues of the study. It also outlines and details the process of ensuring the quality of the current study.

2.1 DESIGN

The current study followed on from the outcome study by McMurchie (2011) on the effectiveness of *Beating the Blues* (BTB), a computerised cognitive behavioural therapy (CCBT) self-help package, in treating older people with depression and anxiety. Participants in the study were allocated to one of two groups according to their treatment preference – *Beating the Blues* and Treatment as Usual (BTB + TAU) or Treatment as Usual (TAU) (see McMurchie *et al.*, in press).

The current study adopted a qualitative methodology using Interpretative Phenomenological Analysis (IPA) (Smith 1996; Smith & Eatough, 2007; Smith & Osborn, 2003) to explore the decision-making processes of participants in the pilot outcome study when choosing their treatment preference. The current study also aimed to explore the experiences of the older people who used the BTB CCBT self-help package.

2.2 ETHICAL ISSUES

2.2.1 Ethical Approval

Before the study was commenced, an application for ethical review by the local area NHS Research Ethics Committee (REC) was submitted. Following the advice of the REC, this was done as a substantial amendment to the existing Integrated Research Application System (IRAS) submitted by McMurchie (IRAS reference 10/S1402/36). There was also a separate submission made to the local area NHS Research and Development (R&D) Office for approval. The study was granted a favourable ethical opinion and was approved by the local area R&D office (see Appendices 1 & 2).

2.2.2 Patient Vulnerability and Distress

The researcher recognised that the study population could be potentially vulnerable, for example, being at risk of developing cognitive impairment and no longer having capacity to consent to participate in research. As participants already participated in the pilot outcome study (McMurchie, 2011), their capability and ability to provide informed consent had previously been assessed and was monitored throughout the duration of the outcome study. Thus guaranteeing the method of recruitment adopted in the current study ensuring all participants had capacity and were able to give informed consent to take part.

While participating in the current study, very few of the participants (N=2) became mildly distressed as a result of the content of the interviews. This distress was in relation to their ongoing difficulties with pain, depression and anxiety. When

participants became distressed, the researcher had the clinical skills to manage participant distress and followed ethical guidelines (Code of Human Research Ethics – BPS, 2010) when doing this. The principles of sensitive interviewing for health care issues were followed in order to minimise distress for participants (Price, 2004). The researcher discussed these issues with their supervisor and ensured participants were receiving adequate support in relation to their difficulties.

2.2.3 Informed Consent

Participants were aware that their participation was completely voluntary. Participants were also aware, through discussions with the researchers of both the pilot outcome and the current studies and in the Participant Information Sheet (see Appendix 3) and Consent Form (see Appendix 4) that they could withdraw from the study at any point without giving a reason and without their routine or future care being affected.

2.2.4 Confidentiality

All information collected as part of the study was collected and stored in accordance with the Data Protection Act (1999). It was stressed in the Participant Information Sheet that participation in the study was confidential. Participants were however advised that confidentiality would be breached if there was an issue of risk to the participant or others. The limits to confidentiality were explained and written consent for audio recording was sought from the participants prior to interview. Participants were assigned unique participant codes in place of personal identifiers for the purpose of transcription, analysis and write up.

2.2.5 Emotional Impact on Researcher

As part of their clinical practice and doctoral training the researcher had experience of conducting interviews, which could potentially be sensitive in nature. There had been no specific risks identified by the researcher. However, in the event of any difficulties arising, the researcher had immediate access to support from their named clinical/academic supervisors for the project.

2.3 SELECTION OF QUALITATIVE APPROACH

Qualitative research is committed to exploring how people make sense of the world and experience certain events in their lives (Smith, Flowers & Larkin, 2009; Willig, 2008). According to Willig (2008) qualitative researchers aim to explore the meaning people attribute to experiencing particular conditions and to managing certain situations. Therefore, qualitative research does not aim to hypothesise the outcome of certain experiences or events, but aims to describe and explain events and experiences. Radley (1999) argues that the experience of health and illness is not an objective phenomenon, guiding the direction of future research towards focusing on patient perceptions on treatment and health related behaviours.

Black (1994) argues that qualitative methodologies are appropriate in exploring complex and sensitive issues, and thereby is an appropriate approach to use within the fields of Clinical and Health Psychology. Covey (1985) reports that qualitative research with older people is conducted frequently, for example, exploring the impact of losing a partner (Golsworthy & Coyle, 1999) and coping with a diagnosis

of dementia (Clare, 2003; Pearce *et al.*, 2002; Robinson *et al.*, 2005). The current study adopted a qualitative approach as it was appropriate to the research questions that aim to capture the older person's individual perspective in order to explore and understand their experiences and the meanings that these hold (Smith *et al.*, 2009). In the current study, a qualitative approach provides an opportunity to hear and understand the decision-making processes and experiences of older people with depression and anxiety using the BTB CCBT self-help programme.

2.3.1 Interpretative Phenomenological Analysis (IPA)

Smith, Flowers and Larkin (2009) describe IPA as a qualitative approach dedicated to exploring the way in which people make sense of significant life experiences. The IPA approach is established from and based on the principles of phenomenology, hermeneutics and idiography. IPA is phenomenological in that it is developed from the work of Husserl (1925) involving a process of conscious reflection upon specific experiences. It is therefore concerned with individual's personal perception of significant experiences. Willig (2008) argues that phenomenology does not make objective claims about the world but states that the person and the world they experience are inseparable. Therefore, the world can only be understood in terms of how the person perceives it. IPA is also derived from hermeneutics (Ricoeur, 1970) through recognising the importance and implications of the interpretative process. Smith (2011) states that IPA involves a "double hermeneutic" (p. 35). That is, the individual is trying to find meaning in their experience and the researcher is attempting to make sense of the individual's interpretation of their experience. IPA recognises that the implications of this

process lie in the researcher's own preconceptions and experiences and the influence these have on their role in the interpretative process. Therefore, the researcher must adopt a reflexive position when conducting IPA through continuously reflecting and critically examining their engagement with the text through a cyclical approach (Smith *et al.*, 2009; Willig, 2008). IPA also adopts an idiographic approach whereby it focuses on the detailed analysis of individual accounts of a particular experience (Smith, 2011). This involves a thorough and systematic analysis of the texts by the researcher. IPA also aims to understand how a particular experience is understood from the perspective of a particular population in a particular context, therefore, using a purposively selected sample. Idiography also involves the integration and comparison of multiple individual perspectives to provide both convergent and divergent themes within the sample (Smith, 2011).

IPA is a well-established qualitative methodology that has been used to conduct health-related research examining the experiences of patients of various health conditions and treatments (Smith *et al.,* 2009). IPA has been used to carry out psychological research with various populations, including older people (Cartwright, 2007; Brooke *et al.,* 2009; Golsworthy & Coyle, 1999; Pearce *et al.*, 2002; Quin *et al.,* 2009; Wolverson-Radborne *et al.,* 2010). This type of analysis has been utilised in exploring a range of sensitive topics, such as living with chronic heart failure, coping with a diagnosis of dementia and the impact of losing a partner. IPA has also been used in research with people with other mental and physical health difficulties including cancer (Chouliara & Kearney, 2007; Hammond & Teucher, 2010), mental illness (Dinos *et al.*, 2004), and personality disorder (Fallon, 2003). It can therefore

be concluded that this qualitative methodology is appropriate to explore sensitive topics (Black, 1994), such as depression and anxiety.

2.3.2 Justification of IPA

IPA was the chosen qualitative approach in the current study. However, the following alternative approaches were also considered when developing the current study: Discourse Analysis and Grounded Theory.

2.3.2.1 Discourse Analysis

Discourse Analysis (DA) is concerned with the productive use of language to construct versions of social reality and achieve personal, social and political objectives (Willig, 2008). In research, DA aims to understand how people use language to create and enact identities and activities (Stark & Trinidad, 2007). Within psychology, DA challenges cognitivism through arguing that it is established on a number of speculative assumptions regarding the relationship between language and representation. DA states that to make sense of individual accounts, the social context in which they are spoken must be considered (Willig, 2008). It was felt that DA was not suitable to the research aims of the current study. DA focuses on the dialogue and how people use language to tell their story. The outcome of DA concerns a description of the language in use whereas IPA focuses on individual perceptions of a particular lived experience. It was felt IPA was more suitable as it is concerned with describing the meaning of the lived experience of a particular phenomenon. According to Smith & Osborn (2008), unlike DA, IPA recognises

cognitive processes and emotional states, the link between them and the individuals' accounts of their experiences.

2.3.2.2 Grounded Theory (GT)

According to Glaser & Strauss (1967), the goal of GT is to develop a theory that is "grounded" in the data through the construction of categories. The resulting theory provides a structure to understand a specific phenomenon (Willig, 2008). There are similarities between GT and IPA in terms of using thematic analysis as an analytic technique. Both methods also begin their analytic process through analysing individual accounts leading to the integration of multiple accounts. GT is a more established methodology and thus is considered to hold more scientific rigour (Willig, 2008). However, it was felt that GT was not suitable to the research aims of the current study due to the fact that its primary aim is to develop an explanatory theory in relation to the data of a phenomenon. On the other hand, IPA takes on a phenomenological approach that is discovery-oriented. The main goal of IPA is to provide a detailed description of an individual's lived experience (Smith, 2011). The current study aims to explore the decision-making processes and experiences of individuals using BTB without the aim of developing an explanatory theory, which fits more neatly with the primary goal of IPA rather than GT.

2.4 REFLECTIVE PROLOGUE

As a Trainee Clinical Psychologist completing two placements within the Older Peoples Psychological Therapies Service, I gained clinical experience of working with older people who had depression and anxiety. Furthermore, through working

within an Adult Mental Health Team, I also had experience of referring individuals to use BTB in addition to conducting further psychological therapy with individuals who had previously used the programme. I had therefore become aware of the effectiveness of this mode of psychotherapy intervention with adults (under 65 years). However, I was aware this treatment was not readily offered within older peoples' mental health services. Furthermore, I had also become aware that little is known on why this mode of psychotherapy intervention appears to be acceptable to adults, and more recently with older people (McMurchie, 2011). I therefore recognised that there was a need for myself and other professionals in this area to develop a greater understanding of older peoples' experiences of using this CCBT programme.

While it has been noticed that older people frequently present with symptoms of depression, it has been proposed that 'computer use may be unacceptable to them' (Kaltenthaler, 2004b: p. 73). A study by Elsegood and Powell (2008) explored, through using a survey-based questionnaire, whether older people with depression and anxiety would be willing to engage with CCBT. Results demonstrated that 47 per cent of the respondents indicated an interest in using CCBT and would be willing to learn the necessary skills.

Little research has been completed in the way of qualitatively exploring the experiences of people (both under and over the age of 65 years) using CCBT. Some qualitative work (Beattie *et al.*, 2009; Bendelin *et al.*, 2011; Gerhards *et al.*, 2011) has been conducted exploring the experiences of adults (of working age) who used

CCBT packages and online cognitive behaviour therapy (CBT)[4]. These studies have generated mixed findings and the evidence on the acceptability of this form of CCBT remains limited. A qualitative study was completed by Hind *et al.* (2010) looking at the experiences of depressed patients' with co-morbid physical health problems of two CCBT packages (BTB and MoodGym). The study found this form of treatment was largely unacceptable to this specific patient group as it did not consider the difficulties concomitant with their physical health problems. The authors therefore concluded that adjustments to the package would be necessary.

The current study therefore aims to address the gap in the evidence base through developing a more in-depth understanding of older peoples' lived experiences of using the BTB computerised self-help package. Individual's perceptions regarding what the programme was like to use and the key factors of the treatment intervention that may impact upon individual recovery were explored. It is hoped the results will help to improve our process understanding of the acceptability of BTB when used by older people, and inform the further development of this mode of delivery of treatment intervention as currently this is an under-researched area of psychotherapy with Older People.

A research journal was maintained throughout the research process. This contained reflections on the experience of the study, acknowledgement of pre-existing knowledge of the area, potential bias and influence.

[4] Online CBT is akin to online therapy and utilises a 'live' therapist model as opposed to a self-help package delivered online.

2.4.1 Research Context

Providing information regarding the context in which the study was conducted is recommended in order to limit potential biases. Information on the research context of this study is provided through discussing the background of the researcher, the BTB CCBT self-help package and the Older People's Psychological Therapies Service.

2.4.1.1 Background of the Researcher

The researcher had worked as a Trainee Clinical Psychologist within an NHS Older People's Psychological Therapies Service in two separate placements with a total duration of a year and a half. The researcher had clinical experience of working with older people with depression and anxiety. The researcher had also worked in an NHS Adult (under 65 years) Mental Health Service for four years, which involved referring individuals to use BTB in addition to conducting further psychological therapy with adults of working age who had previously used the programme.

2.4.1.2 Beating the Blues (BTB)

BTB is a computerised self-help programme developed on the principles of cognitive behavioural therapy (CBT). It aims to help people learn to cope with mild to moderate levels of depression and anxiety through teaching practical and lifelong skills. It was developed jointly by Dr Judy Proudfoot and colleagues at the Institute of Psychiatry, Kings College, London and Ultrasis plc (Proudfoot *et al.*, 2003a). The self-help package is recommended in the National Institute of Clinical Excellence (NICE 97, 2006) and Scottish Intercollegiate Guidelines Network (SIGN 114, 2010)

as its effectiveness in treating depression and anxiety in adults has been demonstrated (Kaltenthaler *et al.*, 2002; 2004a; 2006; 2008a).

2.4.1.3 The Older People's Psychological Therapies Service

The Older People's Psychological Therapies Service is part of the mental health service for adults who are 65 years and older. The service covers a wide geographical area that includes both rural and urban regions. The presenting problems of clients include functional problems (e.g. mood, anxiety etc) and organic problems such as dementia. The service comprises of clinical psychologists who primarily see clients for direct clinical contact. Additionally, the team offer supervision, training and consultancy to other staff trained in providing psychological therapies. The service, prior to the study by McMurchie's (2011) study, did not offer BTB as a treatment for depression and anxiety.

2.5 PARTICIPANTS

2.5.1 Participant Recruitment

Individuals who participated in the 'Beating the Blues: Computerised Cognitive Behaviour Therapy for the treatment of depression and anxiety with older people' pilot outcome study by McMurchie (2011) to completion were eligible to participate in the current study. On attending follow-up sessions for the pilot outcome study, the researcher (McMurchie, 2011) introduced the current study as a follow-on study to the one they had just completed and provided a Participant Information Sheet (see Appendix 3) for individuals to read.

2.5.2 Method of Sampling

In qualitative methodology, samples are often selected purposefully in order to explore a particular experience of a specific group. The aim of the current study was to examine the experiences of older people using BTB and the factors that influenced participants' decision-making process in the pilot outcome study when choosing whether they wanted to use BTB or not. It is recognised that qualitative differences in terms of individual experience are likely to be apparent between individuals who completed the BTB programme and those who did not complete the entire treatment programme. Therefore, the sample of individuals included both completers and discontinuers of BTB so that both perspectives in terms of decision-making processes and experiences of using BTB could be understood. Furthermore, sample also included participants who chose not to use BTB and their perspective of their decision-making processes was also explored.

2.5.3 Inclusion and Exclusion Criteria

2.5.3.1 Inclusion Criteria

The inclusion criterion for the current study is that participants had to have participated in the pilot outcome study by McMurchie (2011). In the study by McMurchie (2011), all participants were offered BTB as a treatment for depression and anxiety. Based on their level of participation, participants were either:

1) BTB + Treatment as Usual (TAU) Completers:

   Individuals within the BTB + TAU group in the pilot outcome study who completed the BTB programme and completed end of treatment assessments as part of their participation.

2) BTB + TAU Discontinuers:

   Individuals within the BTB + TAU group in the pilot outcome study who withdrew from treatment after receiving one or more sessions of BTB, but completed end of treatment assessment as part of their participation.

3) TAU:

   Individuals within the TAU group in the pilot outcome study who did not chose to use BTB and opted for TAU (see pg. 49-50 for definition) and completed the end of treatment assessments as part of their participation.

The researcher of the current study wanted the overall sample to include participants from all three groups so that issues related to decision-making processes with regards to uptake (individuals who chose or declined BTB) and drop-out (individuals who discontinued from BTB) could also be explored in addition to the experiences of using BTB.

2.5.3.2 Exclusion Criteria:

The identified exclusion criteria for the current study include:

- Participants, regardless of their treatment preference, who withdrew from the pilot outcome study and did not consent to complete end of treatment assessments.

- If participants had been diagnosed or were being investigated for dementia in the time between completing the pilot outcome study and when approached about the current study.
- Individuals currently presenting with acute psychotic symptomatology.
- Individuals currently presenting with active suicidal ideation.

The total number of individuals who were approached regarding the current study, including the number who were excluded and the total number who participated is outlined in Figure 2.1.

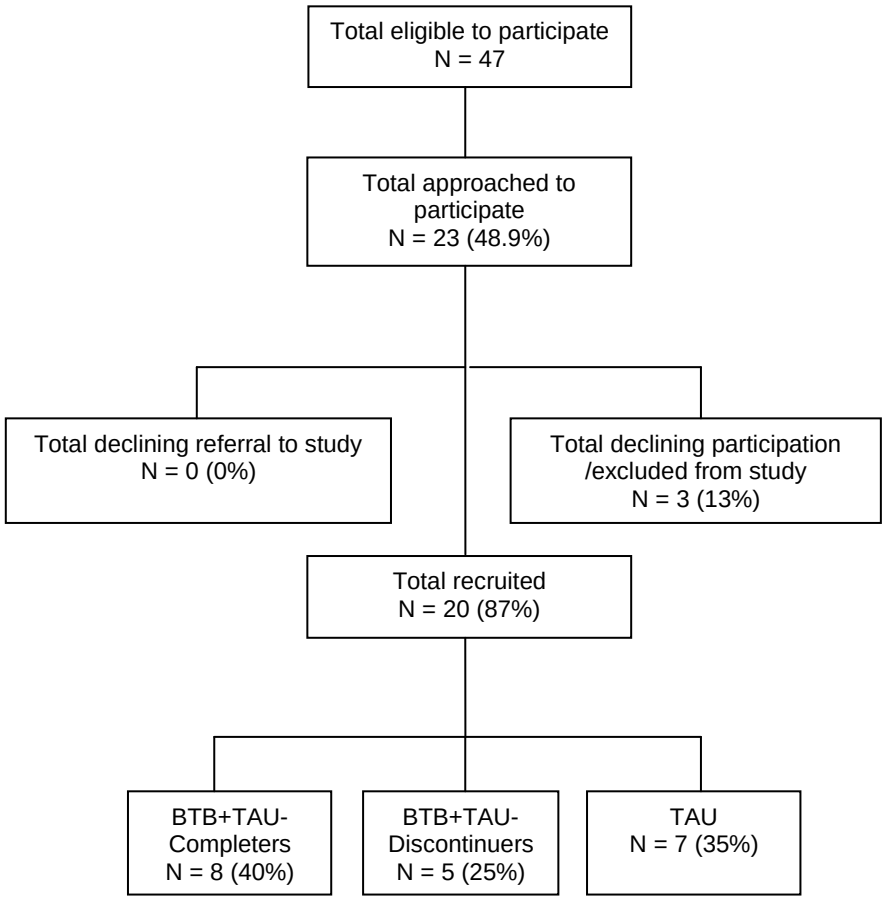

Figure 2.1 Flow chart showing number of participants identified, excluded and recruited.

2.5.4 Participant Characteristics

Twenty participants took part in the current study. Of this 20, there were participants who completed all eight sessions of BTB (N=8), discontinued BTB prior to completion (N=5), and declined to use BTB while remaining with their TAU (N=7). A summary of participant characteristics is presented in Table 2.1. Ages of the participants ranged from 67 to 84 years (M = 74 years; SD = 5.2). Out of the 20 participants, 14 were female and six were male. Participants' self-reported levels of experience and confidence in using a computer was obtained from the demographic forms they completed in the pilot outcome study by McMurchie (2011).

2.5.5 Sample Size

Following the guidance of Smith and Osborn (2003) the current study aimed to have an overall sample size of 18 – 24 participants. It is recommended that a sample of four to ten interviews in professional doctorates is sufficient (Smith *et al.*, 2009), however it is recognised that larger samples may provide richer and more detailed accounts of the phenomena under investigation (Smith *et al.*, 2009). The study aimed to achieve a sample of this size to maximise the potential for the data to contain a wide range of descriptions in order to achieve maximum variation of personal experiences (Smith & Osborn, 2003). However, the principles of sampling to saturation was applied whereby recruitment stopped when it became clear from the analysis of interviews that no further themes were likely to emerge.

The proposed sample size was achieved for the overall sample. However, the group categories within the overall sample varied in size. The current study aimed to have

six to eight participants in each group category. This was achieved in two out of three of the groups. The BTB+TAU-Discontinuers group had a sample size of five. There was a maximum of seven potential participants in this group eligible to participate in this study. All seven participants opted-in, five consented to participate. Of the two that did not participate, one person did not consent, and the other was excluded as they were being investigated for dementia.

Table 2.1 Summary of Participant Characteristics

BTB+TAU-Completers				BTB+TAU-Discontinuers					TAU			
Age	**Gender**	**Experience Using Computer (0-9 Scale)[5]**	**Confidence Using Computer (0-9 Scale)**	**Age**	**Gender**	**Experience Using Computer (0-9 Scale)**	**Confidence Using Computer (0-9 Scale)**	**Number of BTB Sessions Completed**	**Age**	**Gender**	**Experience Using Computer (0-9 Scale)**	**Confidence Using Computer (0-9 Scale)**
77	Male	3	6	76	Female	8	9	4	71	Female	0	0
75	Female	9	9	75	Female	4	4	6	84	Female	2	0
69	Female	5	5	73	Male	5	4	5	70	Male	0	0
67	Female	7	8	72	Female	3	4	1	77	Female	0	0
68	Female	5	6	70	Female	4	2	2	77	Male	0	0
83	Female	0	0						79	Female	0	0
67	Female	5	5						Not Disclosed	Male	0	0
81	Male	6	5									
Mean Age = 73 years (SD = 6.5)		Mean Experience = 5 (SD = 2.7)	Mean Confidence = 5.5 (SD = 2.7)	Mean Age = 73 years (SD = 2.4)		Mean Experience = 4.8 (SD = 1.9)	Mean Confidence = 4.6 (SD = 2.6)	Mean Sessions Completed = 3.6 (SD = 2.1)	Mean Age = 76 years (SD = 5.2)		Mean Experience = 0.3 (SD = 0.8)	Mean Confidence = 0 (SD = 0)

[5] 0 – 9 scale (0 = no experience/confidence at all; 4 = some experience/confidence; 9 = lots of experience/confidence).

2.6 PROCEDURE

The procedure for the study is outlined below.

2.6.1 Initial Approach to Potential Participants

Potential participants meeting the inclusion/exclusion criteria were approached by the researcher of the pilot outcome study, McMurchie (2011), during their follow-up appointment in relation to their participation. Potential participants were offered the Participant Information Sheet and were encouraged to ask questions related to it. The contact details of the researcher of the current study and an Independent Advisor were also provided should they wish to contact them to discuss any initial questions.

Potential participants who expressed an interest in taking part in the study were asked to complete the Opt-In Form (see Appendix 5) allowing their contact details to be provided to the researcher. It was emphasised that they could take more time to consider their decision if necessary. It was made clear in the Participant Information Sheet that through completing the Opt-In Form they were not agreeing to participate in the study, but only to be contacted to arrange a meeting with the researcher of the current study.

2.6.2 Initial Recruitment Meeting

Participants completing the Opt-In Form were contacted by the researcher of the current study and an initial meeting was arranged to discuss the current study, have questions answered and take consent if appropriate.

2.6.3 Pilot Interview

When devising the interview schedule (see Appendix 6), the researcher sought guidance and advice from a clinical supervisor who has extensive experience working in older peoples services and from an academic supervisor with experience in conducting qualitative research in healthcare settings. Both supervisors suggested making minor changes to the wording of questions to reduce ambiguity. The interview schedule was also reviewed and approved by the local area NHS Medical Research Ethics Committee (REC). An initial pilot interview was conducted and the participant was asked to comment on their experience of the interview. Furthermore, an audio recording of the interview was reviewed by the clinical supervisor. Both the pilot participant and clinical supervisor implied the interview schedule was suitable and no further amendments were made. The pilot participant was therefore included in the overall sample (N=20) and the data was incorporated into the results of the study.

2.6.4 Interview Format

Participants met with the researcher to complete a semi-structured interview, which aimed to last no longer than 60 minutes. The interview schedule varied according to which group category participants belonged to. All participants were asked to discuss their decision-making processes regarding their choice to use or not use BTB when participating in the pilot outcome study. Participants who chose to use BTB were also asked to reflect on their experience of using the programme, and if they were a discontinuer, they were asked what they felt contributed towards their decision to stop using BTB at the stage that they did.

The length of the interviews ranged between 15 and 66 minutes. Interviews were conducted at a location chosen by the participants with the option between their home and a clinical space on NHS property. All participants chose to conduct the interview in their homes. Permission was sought to use a digital recorder prior to commencing the interview and participants were informed that all identifiable information would be made anonymous whilst being reminded of the limits of confidentiality.

The questions and permitted prompts for each of the three groups are laid out in the Interview Schedule (see Appendix 6). The interview schedule was used flexibly throughout the interviews. This allowed the researcher to further explore issues raised by the participants. The interview schedule was constructed following guidance from qualitative texts (Smith *et al.,* 2009; Willig, 2008) in addition to advice being sought from one of the researcher's supervisors who is well versed in qualitative research.

Questions were neutral and open-ended and prompts were included or omitted depending on the information provided by the participant. Topics discussed within the interview were guided by relevant literature (Gerhards *et al.,* 2011; Hind *et al.,* 2010) which is limited. Therefore, the interview schedule topics/questions were also guided by previous qualitative research exploring patients' experiences of treatment programmes/interventions (Smith, 2011). The interview schedule included topics on likes and dislikes about BTB, how they found the content and pace, whether BTB helped in their recovery, and if they felt anything could be changed about BTB to

improve their experience of using it (see Appendix 6). Each participant was initially asked "Can you summarise your experience of using BTB?" The question aimed to orient the participants to the research area and to their experience of using the BTB package. It also allowed for further questioning/prompts in relation to their lived experiences of using this treatment intervention, including helpful and unhelpful aspects of the treatment programme, how it impacted their recovery, and how the package could be changed to improve their experience. Participants were also asked "Can you tell me how you decided you wanted/did not want to use BTB?" This question aimed to orient participants to reflect on the factors that influenced their decision-making processes when indicating their treatment preference in the pilot outcome study by McMurchie (2011).

The researcher would follow up questions with prompts to clarify answers. These included asking for further information (e.g. Can you tell me more about that?), clarification (e.g. What do you mean by that?) or asking about emotions in relation to a specific experience (e.g. How do you feel about that?). The researcher also remained silent for a short period following answers to encourage further information. The researcher also made a point of summarising the information provided by the participant to ensure accuracy and let participants know they had been heard. At the end of the interview, the researcher gave participants the opportunity to provide any additional information and they were also asked to reflect on their experience of the interview.

There were a number of issues that had to be considered while conducting the interview, for example, being aware of potential physical consequences of aging such as fatigue, concentration and attention difficulties, and pain. This was monitored throughout the interview and participants were made aware they could take breaks as required.

2.7 DATA MANAGEMENT

Interviews were recorded using a digital voice recorder. On completion of the interviews, the recordings were stored on a NHS password protected computer and NHS encrypted USB stick. Recordings were erased from the recorder upon secure storage. Interviews were transcribed verbatim using transcription equipment with the removal of all personal identifiable information. Each transcript was assigned a unique participant code.

2.8 DATA ANALYSIS

The data for the combined three groups was analysed using a step by step guide to conducting IPA analysis recommended for use by qualitative researchers (Smith *et al.*, 2009). These steps are summarised in Table 2.2.

Table 2.2 Summary of Step Wise Analysis of IPA (Smith *et al.*, 2009)

Step	**Analysis**
1. Reading and Re-reading	This step involved the researcher immersing themselves in the data through listening to and transcribing each individual transcript. The researcher then repeatedly read each transcript and so became actively engaged with the data, allowing them to enter into the participant's world and ensuring the participant becomes the focus of the analysis.
2. Initial Noting	This step involved the researcher examining each transcript at an exploratory level, noting down anything of interest while keeping an open mind. During this step, the researcher began to recognise the ways participants' describe, talk about and make sense of specific experiences through noting down "descriptive", "linguistic" and "conceptual" comments. An example demonstrating this step of the analysis from participant BTB037's transcript is illustrated in Table 2.3.
3. Development of Emergent Themes	While exploring descriptive patterns within transcripts, the researcher began identifying emerging themes. Themes represent the researcher's effort to summarise important reflections in each individual account, involving both the participants' and researcher's interpretation of the event (Smith *et al.*, 2009). Smith and Osborn (2008) state the identification of themes moves the researcher's interpretation of the transcripts to a more conceptual level. Emergent themes were documented in the left hand column of the transcript (see Appendix 7).
4. Searing for Connections across Emergent Themes	Connections between themes were explored to produce master themes that describe a cluster of themes. The researcher completed this task as a paper-pen exercise rather than utilising a qualitative data analysis package (e.g. NVivo). The researcher made this decision after seeking guidance from experts in qualitative research. It was felt that by doing a paper-pen exercise, the researcher was more able to engage with the data at a deeper level to facilitate a richer analysis of the data. Furthermore, the sample size in the current study was sufficient to offer such an opportunity. The researcher produced a table summarising the emergent themes and development of master themes (see Appendix 8).
5. Moving to the Next Case	Following the idiographic principles of IPA, the researcher repeated steps 1 to 4 for each individual account. This allowed the identification of new themes from each transcript.
6. Looking for Patterns across Cases	This step involved the researcher looking for patterns across accounts through comparing the summary tables for each participant. This allowed the researcher to identify shared and isolated themes across the transcripts. Some themes were only identified in later transcripts and so the researcher also went back to earlier transcripts to find examples of these themes.

Table 2.3 Example of Initial Noting

Section from Transcript: BTB037 (I: Interviewer; R: Respondent)	**Exploratory Codes** (Underlined = Descriptive; *Italics* = Linguistic; **Bold** = Conceptual)
I: Can you tell me how the BTB programme has affected you, if at all? R: Yes, oh it's affected me. It's made my life easier. It's made me, it's made me face situations and respond in a way which helps me. I can go back to this, I have to think more positively, I have to think of all the good things.. not to keep harping on about, not to think too far ahead. Just not to think too far ahead. Not to go back, because there isn't any point.	Life is easier; *Emphasising degree in which BTB has helped (repeating 'it's made')*; **Implying life prior to BTB was hard.** Facing situations, responding and helping self; **Becoming empowered – process of change.** Thinking positively; *Emphasising the importance of altering her thinking (repeating 'I have')*. **Process of change – previously focused on the negative and now is more positive and feeling empowered.** Being in the here and now; *Appears to be struggling to articulate some strong emotions (repeating phrase 'not to think too far ahead' and use of 'just').* **Implied uncertainty of what the future holds and perceived lack of control. Sense of there being regrets in the past – losses experienced due to depression?**

2.9 DEMONSTRATING QUALITY

There are well-established criteria for assessing the value and methodological rigour of quantitative research; these are standards of reliability, validity, objectivity and generalisability. Qualitative research is often criticised for failing to adhere to these standards (Yardley, 2000). However, such criteria are inconsistent with the theoretical concept on which qualitative research is based upon. Nevertheless, there are established core flexible principles to assess the quality of qualitative research, these are: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance (Yardley 2000, 2008). The steps taken to follow the above principles are described in detail below.

2.9.1 Sensitivity to Context

Qualitative research is shown to be sensitive to context through an understanding of the existing relevant theoretical and empirical literature and socio-cultural context of the participants (Yardley, 2008).

The researcher was sensitive to the existing qualitative literature concerning older peoples' views of psychological conditions and treatment. The researcher was also sensitive to the limited existing qualitative literature concerning the use of CCBT programmes in the treatment of depression and anxiety across the age span. Yardley (2008) states that the way in which the researcher engages with participants can potentially influence the data in addition to having possible ethical implications. Participants were aware that the researcher was a Trainee Clinical Psychologist and was carrying out the research as part of her doctoral thesis. The researcher was mindful that these factors may have contributed to a perceived power imbalance between the researcher and the participant. The researcher was sensitive to the impact her role could have on participants, for instance, in eliciting views on the BTB treatment programme. The researcher was conscious that participants may have assumed she had an invested role in the BTB programme and therefore be reluctant to discuss their views of the programme honestly. Furthermore, the researcher was also mindful that the perceived power imbalance may operate in the opposite direction. That is, participants may have viewed the researcher to be under-qualified and inexperienced and this could potentially impact participants' willingness to discuss their experiences. Participants were informed that the researcher worked clinically in the Older Peoples Psychological Therapies Service

within their health board and had no invested interest in the BTB treatment programme.

The researcher was also conscious to consider the cohort beliefs of this particular generation (Laidlaw *et al.,* 2003). Participants within this generation may have certain beliefs about discussing their engagement in a psychological programme with a stranger. All participants were given the option of doing the interview in their preferred environment, including their home. The researcher also met with the participants on one occasion before conducting the interview with the aim of establishing rapport and minimising any of the above concerns.

2.9.2 Commitment and Rigour

This principle refers to the need to demonstrate the analysis is of sufficient breadth and/or depth to ensure the validity of results (Yardley, 2008). This is established through extensive engagement with the topic, developing and demonstrating competency in data collection and analysis. The researcher carried out a comprehensive literature review in the area of CCBT in addition to reviewing the use of qualitative research in the older people population. As well as doing extensive reading on the principles of IPA, the researcher also attended an IPA analysis workshop which provided an overview of the principles behind IPA analysis in addition to practicing skills learned on IPA based interviews. Throughout the interview process, the researcher demonstrated commitment through being attentive and sensitive to the information provided by participants *(*Smith *et al.,* 2009*).* The researcher transcribed the interviews and as part of the analytic process, she listened

to the audio recordings while reading the transcripts to facilitate immersion in the data. The researcher also followed the principles of the step-wise framework of analysis presented in Smith *et al.* (2009) (see table 2.3), demonstrating the level of commitment to the analysis.

The concept of rigour in qualitative research refers to the "thoroughness of the study" (Smith *et al.*, 2009, p. 181). Various methods were used to strengthen the rigour of the study, these were: sampling, multiple sources of coding and respondent validity checks. In terms of sampling, the researcher interviewed individuals who had used the BTB programme thereby obtaining a relatively homogeneous sample in this respect. In order to broaden the range of possible perspectives, the researcher also interviewed individuals who used the BTB programme but discontinued before completing the course. This allowed the researcher to potentially access more information on factors that influence participants' decision to discontinue using the BTB programme. Furthermore, the researcher interviewed a third group of participants who had declined to use the BTB programme with the aim of learning more on the reasons for this. To enhance the rigour in this study, the researcher interviewed a large overall sample. This was with the aim of achieving an in-depth analysis permitted within the study time constraints. Following the idiographic principles of IPA (Smith *et al.*, 2009), the researcher engaged in cyclical checking of the identified themes against each individual transcript, ensuring the themes were generated from the data. To demonstrate a detailed and systematic analytic process, the researcher provided supportive quotations from individual transcripts and used summary tables to illustrate patterns of themes.

Barbour (2001) advocates the use of multiple coding to enhance rigour. Samples of coded transcripts were reviewed by the clinical supervisor who had experience of working with older people and entire coded transcripts were reviewed by a researcher experienced in qualitative research. This assessed the degree of concordance between researchers and also aided in refining the themes following alternative interpretations (Barbour, 2001). With regards to respondent validation, that is asking participants to comment on the analysis (Silverman, 1993), the researcher selected three participants (one from each group) and invited them to meet with the researcher in separate interviews to discuss the findings and comment on the identified themes.

2.9.3 Transparency and Coherence

Transparency in qualitative research refers to how well a reader can grasp all aspects of the research process (Yardley, 2008). This was achieved by providing a clear and detailed description of the methods used, for example, sampling methods, the construction of the interview schedule and the process of analysis. This was supported by the researcher keeping a reflective diary throughout each stage of the study. The researcher also provided examples of data through quotations and tables summarising themes to demonstrate the transparency of the analysis.

Coherence refers to the extent the study presents findings consistent with the theoretical background, the research question and methodology (Yardley, 2008). To ensure this was met, the researcher presented samples of transcripts with coding and drafts of the write-up to be reviewed by both clinical and academic supervisors.

2.9.4 Impact and Importance

The final principle refers to the research findings having potential to contribute to theoretical knowledge and/or practice in the specified research area (Yardley, 2008). Kaltenthaler *et al.* (2008b) recommended that future research focuses on the acceptability of CCBT (including BTB) to patients. They proposed studying this through both 'survey and intensive qualitative methods, include the process of initial engagement, continuation versus drop-out, and in those completing, satisfaction or regret undertaking CCBT' (p.1528). The aims of the current study were in line with this recommendation.

CHAPTER 3 – FINDINGS

3.1 INTRODUCTION

The aim of the current study was to describe the experiences of older people with depression and anxiety using the Beating the Blues (BTB) Computerised Cognitive Behavioural Therapy (CCBT) self-help programme. Furthermore, the current study also aimed to explore factors influencing participants' decision to use or not use BTB as well participants' decision to discontinue from using BTB. The interviews were analysed as one large group (N=20) rather than three separate groups. The researcher followed the guidance of Smith *et al.* (2011) and felt this method provided a richer account of both the convergence and divergence of the experiences and decision-making processes of the overall sample. Participants' accounts highlighted both positive and negative experiences of using BTB as well as various factors (both positive and negative) that influenced their decision-making processes.

The analysis initially produced eleven super-ordinate themes from participants' interviews. There were differences in the distribution of the super-ordinate themes within each individual account, and between the three groups. The nature of the current study meant that some of the super-ordinate themes were more relevant to the individuals who used the BTB programme (BTB+TAU-Completers and BTB+TAU-Discontinuers) rather than individuals who chose to remain with their treatment as usual (TAU) and vice versa. Taking this into account, the distribution of the super-ordinate themes was more prominent amongst certain groups depending on what the

theme represented. Each super-ordinate theme recurred in at least a third of the sample of individuals that theme was relevant to (never more than two groups), rather than the overall sample (all three groups). Each of the eleven initial super-ordinate themes was reviewed against each individual transcript comparing how the participant reflected on their experiences and decision making processes (see Appendix 9). The initial eleven super-ordinate themes were then clustered into five master themes of which the researcher felt represented the overall experiences of the sample. These were:

- *Beating the Blues as a Process of Change;*
- *'That's not my situation': Relevance of Beating the Blues to Older People;*
- *'I thought it would be easy and it wasn't': Challenges of Using Beating the Blues;*
- *Motivation to Try Something New;*
- *Barriers to Beating the Blues at Time of Uptake.*

Some participants (BTB024, BTB026, BTB029, BTB037, BTB047 and BTB056) provided detailed and rich descriptions of their experience of using BTB, thereby covering a greater number of the sub-themes. With the exception of participant BTB029 (BTB+TAU-Discontinuer), all of the above participants were within the BTB+TAU-Completers group and the greater detail of their interviews may be a reflection of their longer use of the programme and consequently experiencing more features of the BTB programme. The remainder of the participants did not necessarily provide less detailed narratives, but overall had less to say due to either not using the BTB programme or only using it for a more limited period of time.

Thus these participants covered fewer of the sub-themes overall. A summary of the master themes and related sub-themes is presented in Table 3.1.

Table 3.1 Summary of Master Themes and Sub-Themes

Master Themes	**Sub-Themes**
1. Beating the Blues as a Process of Change	1.1 Initial Impressions; 1.2 'As I got into it': Developing Awareness and Reinforcing Previous Treatment; 1.3 Making Changes: Thinking Positively and Facing Situations; 1.4 Feeling Empowered and Moving Forward.
2. 'That's not my situation': Relevance of Beating the Blues to Older People	2.1 'Not geared for my age'; 2.2 Absence of Physical Health Issues;
3. 'I thought it would be easy and it wasn't': Challenges of Using Beating the Blues	3.1 'Harrowing to go through everything'; 3.2 'Prefer talking to someone, not this disembodied computer'; 3.3 Coping with Technical Glitches.
4. Motivation to Try Something New	4.1 'Sink or swim': Nothing to Lose; 4.2 Contributing and Feeling Validated; 4.3 Recommendation of BTB and the Therapeutic Relationship; 4.4 'I've got a chemist shop through there': Saying No to Antidepressants.
5. Barriers to Beating the Blues at Time of Uptake	5.1 Familiarity and Confidence with Technology; 5.2 Depression, Physical Health and Life Events.

Detailed descriptions of each master theme and related sub-themes are presented below including direct extracts from participant interviews. The selected extracts were chosen as they provided the most articulate expression of the themes, while also representing both the shared and contradictory views of the sample. All extracts have been anonymised and the source of each extract is indicated by the unique participant code which also indicates the group they belong to. A summary of the relationships between the master themes is also presented to reflect the meaning of

the experience of the BTB programme and the factors that influenced the decision making processes of the participants.

3.2 OVERVIEW OF THEMES

3.2.1 Beating the Blues as a Process of Change

The first master theme, "Beating the Blues as a Process of Change", describes participants' experiences of change in their ability and confidence to cope with their depression through using the BTB programme. This process of change was often described as a journey, whereby participants' levels of confidence altered the further into the programme they progressed. This master theme is comprised of four sub-themes:

1) Initial Impressions;
2) 'As I got into it': Developing Awareness and Reinforcing Previous Treatment;
3) Making Changes: Thinking Positively and Facing Situations;
4) Feeling Empowered and Moving Forward.

3.2.1.1 Initial Impressions

Several participants talked about their early experiences of BTB describing initial feelings of uncertainty in trying something new and unknown. A few participants talked about feeling apprehensive and overloaded about the process of learning, implying that they felt they were a student learning a new subject. There were some elements of fear in this, fear that they will not manage it and fear that they were too

old to learn something new. This belief perhaps represented a negative self-perception of aging, where older people perceive they will struggle to learn new skills compared to younger adults, arising from a combination of previous experience and exposure to negative age stereotypes. For some, there were initial feelings of doubt whether the BTB programme was for them, or if it would help them.

> *"...well I was a wee bitty, well like I suppose with any learning thing, you know, you're a wee bitty 'am I going to be able to this' again negative, you know. I thought 'oh God, I'm nae use at studying and learning and that, I'm too old for this'..." (BTB028, BTB+TAU-Completer)*

> *"...initially I found all the exercises a bit of an overload, you know. There was a lot to do." (BTB037, BTB+TAU-Completer)*

> *"I found it at first, when I did the first lesson, I wasn't particularly looking forward to the second lesson. I thought, you know, I don't know why, maybe the introduction one was not really what I wanted..." (BTB056, BTB+TAU-Completer)*

> *"Well to begin with, I wasn't very sure. I wasn't and as I say, the first one wasnae what I-I just didn't take it in right, you know, it took a wee while to understand what it was about that...It didn't seem to be very interesting." (BTB041, BTB+TAU-Completer)*

3.2.1.2 'As I got into it': Developing Awareness and Reinforcing Previous Treatment

Participants talked about settling into the BTB programme after completing a 'few' sessions. For some, this meant developing a better understanding of the programme, the style of questioning it had and starting to feel the benefit of it. Some participants described the BTB programme becoming a 'discipline', something they had to make time for and persevere with for it to eventually become part of their day-to-day life.

Participants also perceived BTB as an 'authority' which appeared to motivate participants to complete the sessions and feel empowered.

> *"...but once I got into it, I did look forward to them..." (BTB056, BTB+TAU-Completer)*

> *"...and then a few after that you thought 'oh God, I feel great', you know, it sunk in to you then, you know." (BTB041, BTB+TAU-Completer)*

> *"It was making the time to follow the instructions or to follow bird watching and I had, because it's almost, it's a discipline the programme. It was a discipline and I kind of need that, otherwise I think I'll do it later. But because I had this deadline every week, I had to report back and fill out, you know. It was authority, it was teacher. I felt 'right, I've got to do this' and then it becomes easier. So it's easier to follow because you're getting into a routine." (BTB037, BTB+TAU-Completer)*

Several participants discussed focussing on parts of the programme they felt was more relevant to them and their difficulties, providing them with a positive sense of control and facilitating their engagement with BTB.

> *"I extracted what I needed, what helped me." (BTB037, BTB+TAU-Completer)*

> *"...it's not an individually tailored programme, it's a catch-all thing and I didn't find that too much of a problem because you can always take the bits that are relevant to you from it, you don't have to take it all, it's for you really." (BTB047, BTB+TAU-Completer)*

Several participants described developing a clearer perception of the severity of their difficulties, how they developed and how they are maintained. The researcher felt this enabled participants to develop insight into their difficulties and gain a sense of hope in overcoming their difficulties.

"I think that's the whole point, to make you aware of what you're doing wrong or thinking wrong." (BTB047, BTB+TAU-Completer)

Some participants also talked about starting to make sense of their difficulties through realising there were others with problems they perceived to be more severe than their own. Through developing this sense of perspective, participants were able to normalise their difficulties and overcome the isolating nature of depression. In this respect, BTB appeared to mimic the process of group therapy, whereby participants develop a sense of identity through belonging to a group.

"...as if you weren't alone sort of doing it, you know, other people were trying to work through this as well, they had their own problems." (BTB047, BTB+TAU-Completer)

"Realising that there were an awful lot of people worse off than I was. When I looked, studied the various examples of people with different problems in different stages of their life." (BTB029, BTB+TAU-Discontinuer)

For some, the BTB programme reinforced previous treatment experiences, reminding them of strategies they had used in the past. This appeared to tie in with feeling empowered, where participants accessed previously learned skills and developed a sense of hope in recalling how these helped, which facilitated their journey towards recovery.

"There were things that of course I recognised from previous things, you know, the things the way your mind works, you know, you kind of get into behavioural patterns that are wrong and how to get out of them, that was I think that's the main thing of it, that being cognitive behavioural therapy, because of that and I found it helpful. (BTB047, BTB+TAU-Completer)

> *"...I've done cognitive therapy before anyway, many years ago, so it's not entirely new to me, but it was useful to have a refresher course, as it were, to remind me how to cope with worrying situations." (BTB026, BTB+TAU-Completer)*

However, some participants talked about BTB being less helpful than they hoped it would be as they did not learn any new strategies.

> *"I think the fact that some of the things I was reading about I already knew, maybe I was whizzing through it too fast on some days Just not sure, but I mean it was informative, though I'm not sure it was terribly helpful." (BTB026, BTB+TAU-Completer)*

> *""...it's something new, it might just pull something out the hat that we haven't got before. I don't think it did really. After three or four sessions I became aware that I was covering a lot of old ground in that it was asking me and also suggesting to me certain procedures for dealing with problems that I had covered dozens of times with other people or in my mind." (BTB024, BTB+TAU-Completer)*

Some participants had extensive treatment for longstanding depression throughout their life, which reflects their knowledge and awareness in well-practiced psychological interventions. Therefore, for some there was a hope that trying something new like BTB would provide the solution to their problems that they had previously been unable to find. BTB not providing this appeared to represent a loss for these participants, a loss of hope which seemed to halt their journey of becoming empowered and moving towards recovery.

Two participants suggested that BTB may be more beneficial as a first-line treatment for depression in individuals experiencing their first episode as they may not find the content of BTB to be repetitive of their previous treatment experience. There is the

perception that using BTB in this way means those individuals may have no preconceptions of what to expect from BTB and this may instil hope and facilitate their engagement with the programme.

> *"If that were done say at the beginning of somebody's period of depression, where I think it might be more useful than somebody who's been depressed for a while." (BTB024, BTB+TAU-Completer)*

> *"...I thought it would be really really good for people that never had therapy before..." (BTB039, BTB+TAU-Discontinuer)*

3.2.1.3 Making Changes: Thinking Positively and Facing Situations

Several participants within the BTB+TAU-Completers group discussed how the BTB programme encouraged them to alter their thinking styles, from negative to positive. Participants discussed taking on a more methodical approach to their thinking, being more logical and discarding erroneous unhelpful thoughts.

> *"Well it made you think about things in a different way. Instead of being, you know, instead of thinking everything was doom and gloom, there were other ways of looking at things. So you know, like everything isn't black and white and you can talk yourself or think yourself out of situations that are crippling. So I found that quite useful." (BTB026, BTB+TAU-Completer)*

> *"I learnt to turn my thoughts round cause I was very, when I, you don't realise all the time when you're down, but when I realised, I realised I can't go on like this... so I had to change my thinking. I think going from the negative thinking to the positive thinking..." (BTB037, BTB+TAU-Computer)*

For some participants, the programme also encouraged them to do more; this included being more active, socialising and tackling situations that they previously

avoided. For most, thinking positively and facing situations was described as a helpful aspect of the programme as it increased their sense of enablement.

> *"And it made me do things, like I went and asked my GP to do exercise classes, which I did the 12 week course and kept it up, I'm still doing it...still going twice a week and I never did that before." (BTB047, BTB+TAU-Completer)*

> *"I know myself it took me out more. I was up every day, just for a walk...it gave me energy to get on and clean. You know, do things I'd normally say 'oh I'll leave that for after, till another day' and that, whereas I'd say 'no, I'll get it done today and that will be it done'." (BTB041, BTB+TAU-Completer)*

Participants described executing self-agency through making positive health-related decisions independently. This enabled them to gain a sense of achievement and empowerment, which increased their sense of coping and positive self-image.

3.2.1.4 Feeling Empowered and Moving Forward

The majority of participants within the completers group described the process of feeling empowered as seeing the solution to managing their difficulties independently. It was perceived as reaching a point in their recovery journey where participants experienced BTB as a credible treatment, thus feeling secure in their ability to cope and developing a greater sense of self. There was a shared consensus that this involved managing challenging situations in a more helpful way, trying new things, and living their life free of depression and anxiety. There was also an implicit sense that participants developed hope for the future.

"...it was like the solution was there in front of you, you know you could read the solution and take your problem. I mean it's great to have somebody telling you, I know that, and it does make you feel better but I just felt that sometimes there was once or twice that I'm reading all of this and I thought 'God, that's the solution there in front of me, and I don't have to ask somebody else'..." (BTB028, BTB+TAU-Completer)

"I'm still quite pleased with it, yeah, I thought it was very helpful to me and it made me do things and get out of what I was, well where I was in my life, it wasn't a good place and I've made adjustments and I've gone out and done things I wouldn't have done maybe before I done it. So I think that's a qualified success, wouldn't you say?" (BTB047, BTB+TAU-Completer)

"No it's helped in loads and loads of ways. Just getting up in the morning, just facing the day, just taking all the positives out of the day and that I have in coping with those situations which are not so good." (BTB037, BTB+TAU-Completer)

3.2.2 'That's not my situation': Relevance of Beating the Blues to Older People

The second master theme, "That's not my situation: Relevance of Beating the Blues to Older People", represents the perceptions of the suitability of BTB to older people. This master theme is comprised of two sub-themes:

1) 'Not geared for my age';
2) Absence of Physical Health Issues;

3.2.2.1 'Not geared for my age'

Some participants described a sense of being unable to wholly relate to the BTB programme and tying this into finding it difficult to identify with the five case

examples shown throughout the programme. Participants discussed there being one age appropriate case example, a lady who had been bereaved, which the majority followed through the programme. All the participants who followed this case example stated that the lady's situation was not the same as theirs as they had not been bereaved. The other case examples were characterised as 'young' and their situation or attitude were ones participants may have related to some years ago, but not now. Participants consequently expressed a sense of dissatisfaction with this aspect of the programme.

> *"...again with the one exception, I didn't think that it was meant to relate to over 65s, there wasn't a great deal of relevance to over 65s. I think there may have been one example case, I think it was loneliness, the other person, that's all I can say about that." (BTB029, BTB+TAU-Discontinuer)*

> *"I couldn't really identify with many of the people that were appearing on it, and I think that was probably because we were of a different age group. I mean, I'm now 74 and a lot of the people that were taking part in the computer thing, they were young people, apart from the retired woman. So and they were working, so I couldn't identify with them much, and some of the things like why they were depressed because maybe things weren't going well at work or they thought someone at work didn't appreciate them, I found it difficult to identify with that because I'm not in a work situation any more. (BTB026, BTB+TAU-Completer)*

> *"I did find though that the five models of people concerned, I only related to one or two of those. It wasn't geared for my age and that one I did latch onto was the lady, but I found that she was more suffering from losing her husband...which was not my situation, it wasn't that at all. So that was a little bit difficult, well not difficult, it was a little bit off-putting in that respect. The young student, the young teacher, I found I related to him on the basis of he is a professional person, I was a professional person and I could relate to him in that respect. But his attitude was a young attitude and it was not my attitude in many ways I would say." (BTB056, BTB+TAU-Completer)*

The lack of identification with the case examples appeared to increase the sense of isolation that comes with depression. It was perceived that the absence of older people in the programme resulted in participants feeling under-represented, misunderstood and under-valued. There was an implicit sense that the younger case examples prompted participants to recall their past self which may have led to them making comparisons to their present self. This may have evoked negative emotions related to perceived losses experienced through aging. However, there were two participants who, while noticing that the majority of case examples were younger people and not necessarily being able to fully relate to them, felt that age was not an issue.

> *"I don't think age comes into it much. I mean age brings different problems such as rheumatic ankles, something I've got, but there are still problems. I mean my grandson was here the other day talking about the problems of juvenile acne and people still have these problems to face - problems with career choice, and if not career choice what they do with their lives and their life patterns and so forth. So I don't think age comes into it a great deal, I think there's too much made of age differences." (BTB024, BTB+TAU-Completer)*

> *"I had a look at them all, so I thought it was quite, it wasn't just for young people or just for old people, it was for everybody really. I found that quite good because problems are problems no matter what age you are really, some are more relevant to older people." (BTB047, BTB+TAU-Completer)*

Participant BTB047 goes further to state her opinion that difficulties with depression are not restricted by age, indicating her perception that people of any age who are suffering from depression could find benefit in the BTB programme.

> *"Depression or whatever, mind set or false thinking and all that, I mean that happens at any age depending on your circumstances." (BTB047, BTB+TAU-Completer)*

The perception of age not being an issue appears to represent the voice of older people who are reluctant to be pigeonholed into an arbitrary definition of what is considered an 'older person'. It seems that some individuals based their self-identity on the distinctive characteristics belonging to them, as opposed to belonging to the social category of 'older people'.

3.2.2.2 Absence of Physical Health Issues

For some, the absence of physical health issues in the case examples was unsatisfactory as they considered it to be a universal experience of ageing and a dominant aspect of their own experience of depression. The shared consensus is that to make the programme more relevant to older people, physical health issues needed to be considered and included within the case studies presented. Similar to the above theme, the perceived lack of age-related material in BTB resulted in participants feeling misunderstood, under-represented and under-valued. It also seemed to increase their sense of hopelessness as the BTB programme was not tackling the issues they were presenting with, thereby, feeling as though it is unlikely they will overcome their difficulties with depression.

> *"But mine's was more health-wise...but when you went into it to see the people, what like they were, I felt everybody was different. They had different circumstances..." (BTB040, BTB+TAU-Completer)*

> *"I felt that one of the things that could have been dealt with was maybe the fact that older people have a lot of pain to put up with and that can cause depression...by the time you're in your 70s you're getting things like arthritis and so on and that be very debilitating and depressing. So that sort of thing I feel isn't being covered..." (BTB026, BTB+TAU-Completer)*

3.2.3 'I thought it would be easy and it wasn't': Challenges of Using Beating the Blues

The third master theme represents the negative experiences of using BTB. It comprises of three sub-themes, these are:

1) 'Harrowing to go through everything';
2) 'Prefer talking to someone, not this disembodied computer';
3) Coping with Technical Glitches.

3.2.3.1 'Harrowing to go through everything'

Some participants described their situation preventing them from getting the most out of using BTB. One participant talked about BTB bringing up issues they had previously dealt with and did not want to revisit.

> *"...I thought it would be easy and it wasn't, it raised a lot of questions that I'd previously been through before with a therapist and I didn't like that because it was past and done...it's quite harrowing sometimes to go through everything, all the feelings you had when you were depressed and everything like that...I didn't want to go through all that again." (BTB039, BTB+TAU-Discontinuer)*

Re-living her difficulties with depression appeared to evoke fear in participant BTB039, perhaps a fear of her depression resurfacing as a result. There was also an implicit sense of an underlying cohort belief in relation to being reluctant to discuss personal difficulties.

Participants discussed perceiving their symptoms of depression and anxiety as creating a barrier, and for some their symptomatology increased as they used the BTB programme leading to their decision to stop using the programme. This perhaps reflects the nature of the initial stages of therapy whereby people have to discuss matters of a sensitive nature which can result in an initial worsening of their symptoms before deriving any benefit.

> *"I think it definitely made me feel worse when I was doing it." (BTB053, BTB+TAU-Discontinuer)*

> *"...as time went on I was beginning to feel really, really unwell, and I think that maybe had something to do with it, that I was seriously unwell and I felt it was putting pressure on me because I was so unwell, but I wasn't coping and I did have to say to [name of referrer] [6], look, I can't do it anymore." (BTB005, BTB+TAU-Discontinuer)*

For one participant, there was a perception that their low mood created a barrier to using BTB but through perseverance they were able to complete the programme.

> *"I found it difficult sometimes because of mood. I think, I well, I more or less made, well I won't say made myself, yes, I made myself, once I was caught into it, I decided I would try and go through it." (BTB056, BTB+TAU-Completer)*

There is an importance of motivation when engaging in any form of therapy and it appears that those who struggled to find the motivation were more likely to discontinue BTB. Participant BTB056 appeared to feel motivated and have the psychological resources in place to manage perceived challenges and subsequently complete BTB.

[6] Name of referrer has been omitted to protect anonymity.

3.2.3.2 'Prefer talking to someone, not this disembodied computer'

Several participants talked about the BTB programme missing the personal contact you get from seeing a therapist one-to-one and therefore feeling 'alone'. Some participants discussed the value of having some kind of support mid-way through the programme in the form of meeting with a therapist, whilst others stated they preferred having the personal contact offered in one-to-one therapy over BTB completely. For some participants, there was a desire for seeking support and reassurance while working through the programme.

> *"...maybe having some contact with the psychologist on a sort of casual basis, maybe every two or three weeks, in case there's anything that could be brought up that you haven't quite understood." (BTB026, BTB+TAU-Completer)*

> "*...maybe half way through it we could have had a little catch up with somebody, just to see how you were getting on...just to make sure you were doing, you were on the right track and doing it correctly." (BTB047, BTB+TAU-Completer)*

> *"...there were times when I was, I wouldn't say lonely, but I felt alone. There might have been benefit in having someone else there or even somebody there afterwards." (BTB024, BTB+TAU-Completer)*

Interestingly, participants BTB026 and BTB047 both acknowledged that additional personal contact may defeat the purpose of low-intensity interventions but still felt that some form of additional support would be beneficial. This desire for additional support was perceived to represent participants seeking a secure base while exploring a novel treatment, someone to discuss their experiences with and seek reassurance from while using the programme.

Participants also highlighted how feelings of isolation can occur when undertaking self-help programmes compared to one-to-one interventions which can lead to feeling that no one is taking notice of their problems, they are not being listened to and feeling unable to elaborate their answers due to perceived restrictions of the BTB programme. This perception suggests feelings of being unheard, invisible and marginalised, a sentiment often shared by older people.

> *"There is this lack of personal contact that I felt either it wasn't going to lead to any discussion or nobody was really taking in the detail." (BTB024, BTB+TAU-Completer)*

> *"Sometimes if you're doing things on your own, it gets a bit isolated and you think 'I wonder, I hope I'm doing this right'." (BTB047, BTB+TAU-Completer)*

> *"...if I'm seeing someone one-to-one at least I can then expand on the things I mentioned as being a disadvantage in Beating the Blues..." (BTB029, BTB+TAU-Discontinuer)*

One participant raised the shared impression that older people struggle with loneliness and how this aspect of their presentation is unlikely to respond to a programme like BTB.

> *"...they probably have a bigger problem with loneliness than younger people, so facing a computer isn't really an answer to that." (BTB024, BTB+TAU-Completer)*

For some, there was a sense of finding the BTB programme artificial and therefore struggling to converse with a computer in the same way they would with a therapist. The struggle to form a therapeutic relationship results in participants perceiving a

lack of personalised attention, empathy and encouragement which all facilitate engagement.

> *"I think all that I've had in the past has always been with another person and not this disembodied computer thing." (BTB039, BTB+TAU-Discontinuer)*

In contrast to this view, Participant BTB047 discusses anticipating doing therapy through a computer to seem 'artificial' and finding this was not the case.

> *"...but it's always good just to maybe sometimes just go back and listen to somebody telling you, or not telling you, but working through it with you, even if it is a disembodied voice. But it didn't seem like that at the time, it seemed quite friendly...I thought at first it would be very artificial, but it didn't seem like that somehow, it seemed they had pitched it just right with the voice and it seemed genuinely with you rather than against you, or not trying to sort of be condescending against you." (BTB047, BTB+TAU-Completer)*

It seems that BTB047 adopted a more flexible approach in using BTB and she was able to draw parallels between one-to-one therapy and BTB.

Some participants discussed who they felt the programme is better tailored for. There was a shared consensus amongst the discontinuers group that while they did not find BTB helpful, they could appreciate the benefit of BTB to others. This perception may reflect participants' insight in recognising that no mode of psychotherapy is suitable for everyone rather than viewing their struggle with BTB as a personal failure, a cognitive distortion often witnessed in depression. This adaptive response

may be explained through older people demonstrating greater awareness of situations that they are likely to carry out and therefore find rewarding.

> *"I thought it would be really really good for people who had never had therapy before that had experienced that with a psychologist or whatever 'cause they wouldn't have any preconceived ideas or compare it and say, like me, I wish I were speaking to somebody." (BTB039, BTB+TAU-Discontinuer)*

> *"I'm saying it's not for me, only for me, not for other people. I think it's a good programme but unfortunately not for me." (BTB005, BTB+TAU-Discontinuer)*

One participant queried if this mode of therapy would be better received by younger people who she perceived to have more experience with technology and therefore more likely to engage with CCBT.

> *"I just felt it wasn't working for me at all because maybe because of my age. I think younger people might benefit from it because they're used to communicating via computer or email or whatever..." (BTB039, BTB+TAU-Discontinuer)*

This statement represents a negative age stereotype that because of their age, older people would find computer usage unacceptable.

3.2.3.3 Coping with Technical Glitches

Most participants who used the BTB programme described the practicalities of using a computer to be relatively 'easy'. Many participants who used BTB had previous experience of using a computer, either in their job or in their personal lives. However, some participants did discuss times when the computer was not working properly and the challenges this caused when using BTB.

"I got one or two hiccups with the computer, that was fading out and had not actually given the printouts clearly...but in so far as that was concerned, I was aware it was running." (BTB056, BTB+TAU-Completer)

"...now the odd occasion I found I had to go back and then, it was a bit of a nuisance, because I had to back through a number of pages of what I was answering because I left the computer about ten or fifteen minutes, you know, if it was a break I couldn't help, I found that was a bit of a nuisance. I couldn't just take up at the point I'd left off." (BTB029, BTB+TAU-Discontinuer)

"I think there was once or twice when I thought I could go back over that but I didn't quite know how to do it..." (BTB024, BTB+TAU-Completer)

However, contrary to the experiences of participants BTB029 and BTB024, other participants discussed finding returning to the programme after a break or to review relatively 'easy'.

"I found it was easy to back into the programme to if I wanted to put it on again." (BTB056, BTB+TAU-Completer)

"You were able to do it at your own pace, you could stop it if you want, and carry on, you know later on". (BTB047, BTB+TAU-Completer)

Participants discussed the support system they had in place to deal with technical problems, often through relying on family members. This generally involved enlisting the help of their spouses or their children and grandchildren. Some participants also sought support from the person who referred them to BTB who participants perceived to be more familiar and confident with technology. Participants demonstrated adaptive coping skills through accessing support and were able to overcome some of the technical difficulties they faced early on. Such coping behaviour also demonstrated to participants that support is available and therefore

challenged the feelings of 'isolation' experienced by participants as highlighted above.

> *"I am self-taught, so I've got no backup. My backup is my 12 year old granddaughter who comes in and does that, that and that and I say 'hang on a minute, wait, what did you do there?' but she kind of sorts me on that...I enjoy the computer, I don't use it as much as I might, cause I don't think I know my way round it as much as I might. You know my son sometimes says to me 'oh you can get into such and such a thing there, Dad, by doing this' and I say 'oh, can I?' and you know, I don't know that sort of thing." (BTB056, BTB+TAU-Completer)*

> *"My husband helped me a bit as well cause if the laptop plays up...well I'm hopeless" (BTB053, BTB+TAU-Discontinuer)*

> *"...because of the computer playing up it was a bit awkward sometimes because it was just a nuisance. But [referrer's name] was a big help. " (BTB023, BTB+TAU-Discontinuer)*

For some participants, the problems they faced with the technical side of the BTB programme or with their computers led to them choosing to discontinue with the BTB programme. This is discussed later in the analysis.

3.2.4 Motivation to Try Something New

The fourth master theme, "Motivation to Try Something New", represents participants' perception of what influenced their decision to start using the BTB programme. This master theme is comprised of four sub-themes, these are:

1) 'Sink or swim': Nothing to Lose;
2) Contributing and Feeling Validated;

3) Recommendation of Beating the Blues and the Therapeutic Relationship;

4) 'I've got a chemist shop through there': Saying No to Antidepressants.

3.2.4.1 'Sink or swim': Nothing to Lose

Several participants discussed feeling motivated to use BTB as it meant they were helping themselves and represented taking control. For some, they regarded it as important that they did something to help themselves rather than relying on others.

> *"I really only took it on because I thought, 'well look, if you can't help yourself, how is anybody going to help you." (BTB005, BTB+TAU-Discontinuer)*

> *"I just hadnae been feeling just awful right, there were one or two things that I thought, I could feel better, you know, I should be feeling better and so I thought right, it's a good opportunity to see if I can give myself a wee kick start here and you know, start to feel normal." (BTB028, BTB+TAU-Completer)*

> *"It's easier to do it for myself I think, you know, it's a good thing to do it for myself rather than have somebody do it for me." (BTB047, BTB+TAU-Completer)*

For many, the decision to use BTB was also influenced by their perception that they would try anything that might help and thinking they had nothing to lose by using the programme. It was essentially entering in to something new and unknown with a sense of optimism and hope. Participants' motivation appeared to be influenced by their perception that BTB allowed them to be active participants in the treatment process, creating a sense of enablement and empowerment.

"I wasn't going to lose anything by it, so I thought all I had to do was gain something from it and that's I think it was the right way to look at it, going into it hoping that it was going to help." (BTB047, BTB+TAU-Completer)

"...and I thought, it was sink or swim, I either get worse or I try to overcome the way I'm feeling." (BTB037, BTB+TAU-Completer)

In particular for participant BTB037, the programme represented her reaching a stage in her life where she had to make the choice of either allowing her depression to beat her, or to fight back.

Several participants expressed their sense of hope that BTB may help people discover a solution to their difficulties which motivated their decision to use it.

"But I think the fact that there is something there which might help you, then why not try it." (BTB056, BTB+TAU-Completer)

"Anything would be worth it if it means that I can get out and about more and not feel bouts of depression from time to time." (BTB026, BTB+TAU-Completer)

3.2.4.2 Contributing and Feeling Validated

For some participants, the factor influencing their decision to use BTB was the importance they held in feeling they had contributed to something, in this case, research. Many participants discussed their viewpoint of wanting to help by giving something back after receiving years of help and support from services.

"I just felt that well, I'm being helped, I've really got to try and help back...I wanted to try and help those that are trying to help me." (BTB005, BTB+TAU-Discontinuer)

"Well I just thought that if I took part in it, I'd be making a wee contribution...instead of being on the receiving end all the time." (BTB039, BTB+TAU-Discontinuer)

"...it will be nice to do something to help somebody else." (BTB041, BTB+TAU-Completer)

It was perceived that the act of contributing was important to participants, as it created a sense of accomplishment and positive self-image. There was also a sense of feeling they and their problems were being validated by being approached to participate in research.

"I appreciated the fact that somebody was taking an interest in the problem, my problem. I do feel somewhat flattered and slightly excited by taking part in any research programme." (BTB024, BTB+TAU-Completer)

3.2.4.3 Recommendation of Beating the Blues and the Therapeutic Relationship

Several participants discussed the recommendation of BTB as a factor influencing their decision to use it. For most, they expressed a level of trust in the person recommending the programme and holding value to that therapeutic relationship.

"I think that's pretty important, the actual personal contact and because you feel that this person cares and was trying to help. So I think that's got a lot to do with it, it's a relationship and [referrer's name] did suggest this right at the beginning." (BTB037, BTB+TAU-Completer)

"Well it was at their suggestion, she explained it and what it was all about, I don't know how she decided who actually takes part in it or whether you're suitable for it, I don't know how they decide that, but I felt she must have thought I could cope with it, so yeah, I was prepared to give it a go." (BTB047, BTB+TAU-Completer)

It appears that, through trusting the person who recommended BTB, participants were more motivated to engage with BTB and felt able to access to support when necessary. Similarly to participant BTB047's account, many participants described perceiving the BTB programme being well explained to them and knowing there was flexibility in terms of where they used the programme.

> *"He led me into it, he just gave me an outline of what it was and I thought well I can do this in my own home, that's good." (BTB056, BTB+TAU-Completer)*

> *"I wasnae keen at first when he told me about it but when he said that it was done at home on your computer...I thought, yeah, I'll do that." (BTB028, BTB+TAU-Completer)*

Having this level of control seemed to be an important factor when participants decided to use BTB. Furthermore, the knowledge that participants can use BTB in the privacy of their own home also appeared to motivate their decision to use it. This did not only increase a sense of autonomy but also ensured privacy when undertaking a programme that may potentially raise sensitive issues.

For some participants, the understanding there was an element of support available while using it was also described as an influential factor.

> *"I knew that she had told me that if I didn't like it or I could always come back and see her." (BTB047, BTB+TAU-Completer)*

> *"I think just knowing the support's there is vital, I think that's absolutely vital." (BTB037, BTB+TAU-Completer)*

There is an implied sense that participants viewed the referrer as a secure base from which they felt safe and able to embark on a new journey that is utilising an unfamiliar self-help treatment.

3.2.4.4 'I've got a chemist shop through there': Saying No to Antidepressants

For some participants, a motivating factor to use BTB was that it an alternative to medication. The majority of participants who voiced this view were either taking medication for issues other than depression, for example, pain, or had taken antidepressants in the past. There was a general consensus that participants wanted to learn to cope with their depression without taking medication. As stated earlier, a common issue with older people is poly-pharmacy. There was a shared view that participants wanted to avoid taking more medication if there were alternative options. Furthermore, indicating their preference meant that participants were executing choice in the treatment and care they received, which is perhaps something that older people generally feel they cannot do.

> *"I don't want to take more pills...sixteen years I was on antidepressants and that was far too long and I mean, it shouldn't have been allowed, I shouldn't really have allowed it." (BTB047, BTB+TAU-Completer)*
>
> *"I was willing to try to do that because I wanted something to help me apart from these pills." (BTB023, BTB+TAU-Discontinuer)*
>
> *"I've been under the doctor for ages and I've all different, like I've got a chemist shop through there..." (BTB041, BTB+TAU-Completer)*

Some participants perceived that saying no to antidepressants represented seizing control and taking ownership for helping themselves. There was a common sense of

a negative perception of the side effects of antidepressants and this being an unappealing aspect of this form of treatment.

> *"I didn't have to take a tablet every day. I didn't have to be flaked out, I didn't have to be a zombie. I was taking control, and that's what appealed to me. That it was up to me as well. Somebody was handing me this life line and it was up to me." (BTB037, BTB+TAU-Completer)*

> *"I want to be able to cope without pills or find some sort of strategies that you can use without pills and change your life as well." (BTB047, BTB+TAU-Completer)*

It was perceived that locating the psychological resources to be able to help themselves made participants feel empowered and more able to cope with their depression.

3.2.5 Barriers to Beating the Blues at Time of Uptake

The final master theme, "Barriers to Beating the Blues at Time of Uptake", represents participants' perception of the factors that influenced their decision to either not use the BTB programme at all, or to discontinue using it after they started. This master theme is comprised of two sub-themes, these are:

1) Familiarity and Confidence with Technology;
2) Depression, Physical Health and Life Events.

3.2.5.1 Familiarity and Confidence with Technology

All participants within the completers group stated they had previous experience of using computers and felt more confident in their skills. This was also apparent in

their narrative as they all found the BTB 'easy' to use and were able to overcome any challenges they faced. All participants within the TAU group discussed their feelings about computers and technology. The majority of participants in this group stated they had little or no experience of using computers. For some, technology raised a sense of fear and anxiety and they chose to avoid it.

> *"I cannae use a computer. I got a new computer there, got it last year, and I've never even used it." (BTB045, TAU)*
>
> *"You see, I've never used a computer, I wouldn't do that." (BTB052, TAU)*
>
> *"It's simply because of the electronic, I'm not very good at things, I tend to keep away from them because I feel a little bit stupid." (BTB043, TAU)*

One participant discussed having no interest in technology and having no desire to learn how to use it, stating they prefer face-to-face therapy.

> *"...I cannot think that anything I have seen what have you, that anything on a computer is going to help me. I reckon that the best treatment I think for myself is verbal, word of mouth, this, having somebody to speak to." (BTB052, TAU)*

Participant BTB052 also discussed his concerns about security through using technology and this being a major reason for his decision to avoid technology completely and decline to use BTB.

> *"I don't believe the computers have the confidentiality about it, that's what I think, that's why I don't want to put anything or nothing on record and I don't want anything to go on the computer record..." (BTB052, TAU)*

Some participants perceived their age to be a barrier whereby they considered themselves too old to learn to use a computer. For some, there was an indication that learning to use a computer would be an arduous process, and for others, they lacked confidence in being able to master these skills.

> *"I cannae understand the computer, that's why. Can't just, cannae work a computer. My family all have one, but no me. I'm too old." (BTB055, TAU)*

> *"I'm seventy-one now and it takes me all the time to work my mobile never mind computers. I'm not interested, they're trouble." (BTB027, TAU).*

The above extracts highlight negative age stereotypes held by participants in relation to their age meaning they feel they cannot learn the skills necessary to use computers. This may also represent the experiences of the cohort in general as this generation were not exposed to computer technology in everyday life and in those that worked, they may have left the workforce before computers became an integral part of it. For some this manifests as fear and anxiety, and for others it is a lack of motivation or interest.

Within the discontinuers group, some participants discussed their level of familiarity and confidence with technology. One participant perceived the challenge of using the BTB programme and a computer to be too difficult and felt it impacted further on their symptoms of depression.

"...a bit anxious, yeah, because if it would play up I wouldn't...I just got upset and it made me feel worse...I didn't want to do it anymore." (BTB053, BTB+TAU-Discontinuer)

3.2.5.2 Depression, Physical Health and Life Events

Some participants discussed extenuating factors that created a barrier to them choosing to use the BTB programme and/or continue using it. For some participants from the discontinuers group, there were reflections that their depression was too severe when they first started using the programme and therefore feeling they got little benefit from it due to lacking in motivation and struggling to put the effort they felt was required in using BTB. It was perceived that in struggling to use BTB, participants felt an increasing sense of hopelessness. This issue highlights the importance of individuals feeling able and motivated to engage in using self-help otherwise there is a high likelihood of failure which negatively impacts their psychological well-being.

"No it hasn't affected me. Because it hasn't, it didn't help. But I don't think I'm the type to, I didn't give it a chance because of how I felt...I didn't put the effort in." (BTB005, BTB+TAU-Discontinuer)

"I think it was just the way I was feeling actually. I think I was feeling really down when I started it. Maybe if I were feeling the way I am feeling now, I might've been feeling better...but I don't know." (BTB053, BTB+TAU-Discontinuer)

With increased age, there is an increased likelihood of developing physical health problems. Participants talked about their difficulties with physical health problems and their perception of their ill health creating a barrier to feeling able to use BTB or

from finding it beneficial. It was perceived that this experience represented further losses brought on by physical ill-health, a loss that is experienced by many older people.

> *"...I've been so unwell lately that I maybe wouldn't have handled it a lot, more, you know I would have handled it as well." (BTB043, TAU)*

> *"I wouldn't be able to do it, you know. Because I'm having problems like with my clogged arteries and veins in my head, you know, and sometimes my head just going spinning and I don't know where I am. So, that was one of the reasons, you know. I don't want to get involved with computers or anything at all." (BTB027, TAU)*

> *"Well the only thing that I found unhelpful about it was the fact that because I wasn't able to concentrate as I would have liked to be able to concentrate, but that was just because of the pain." (BTB023, BTB+TAU-Discontinuer)*

Participants also discussed the side-effects of the medication they were taking, namely for pain. The side-effects were perceived as preventing them from engaging fully with the programme.

> *"...the only way I can explain it is I think if it hadn't been that I was taking all these painkillers, I think it would have been better. Because of all the stuff I was taking, I think it kept it from helping me so much." (BTB023, BTB+TAU-Discontinuer)*

> *"Though I don't know if I have got as much out of it as I should have done. But it's probably because of my inertia, really. I was taking Amitriptyline at bedtime for pain and I found, I mean I stopped taking it a fortnight ago because it was making me so sleepy and I think that's why I've been so lethargic." (BTB026, BTB+TAU-Completer)*

These extracts raise the issue of poly-pharmacy and the associated side-effects, a known phenomenon amongst the older people population. Both participants express a loss in terms of not benefitting from BTB due to their medication. There appears to

be additional unspoken losses, perhaps missing out on important life experiences as a result of the side-effects. However, there also appears to be differences between the two participants whereby participant BTB026 felt more able to overcome this perceived barrier and complete BTB. This may be due to differences in the severity of pain, levels of motivation to complete BTB or perhaps inner resilience to demonstrate self-agency in relation to health-related choices.

For some participants, the perceived barrier was difficulties within their personal life. For example, bereavements or family issues in general. This led to participants either initially declining to use BTB or feeling unable to continue with it once they had started.

> *"There'd been quite a few things, family thing that had caused us a lot of grief." (BTB039, BTB+TAU-Discontinuer)*

> *"Yeah, that was the top aine but I just lost my brother-in-law and he was a very good mate of mine...I wasn't in a very good place there and in a awfie awfie mood in hindsight." (BTB057, TAU)*

Both participants highlight the challenges of coping with significant life events. It was perceived that, as a result of this added stress, participants struggled to feel motivated to engage in BTB. Furthermore, with regards to discontinuers, the presence of significant life events may have been a final factor influencing participants' decision to stop BTB if other aspects of the programme were unsatisfactory.

Interestingly participant BTB057 expressed an interest in trying the BTB programme now that his life circumstances had settled. He expressed similar views to other participants highlighted earlier of being willing to try anything that may help.

> *"I'd be willing to try it though like you know, if he wants to get to us about it, I'll try anything." (BTB057, TAU)*

Consequently, the researcher arranged for participant BTB057 to be seen by psychology services.

3.3 RELATIONSHIP BETWEEN MASTER THEMES

It is recommended to hypothesise possible relationships between the master themes in order to bring the data to a more conceptual level (Smith *et al.*, 2009). To do this, Smith *et al.* (2009) suggest representing the interconnections between the master themes diagrammatically.

The researcher perceived the Beating the Blues treatment to represent a "process of change" over time for participants who completed the programme. Participants' experienced changes in their perceptions of the utility of the BTB programme, of the personal meaning of depression, in their ability to cope with their difficulties, regaining control and in feeling able to move forward in their recovery. The master themes, '"That's not my situation': Relevance of Beating the Blues to Older People" and '"I thought it would be easy and it wasn't': Challenges of Using Beating the Blues", encapsulate a process whereby participants reflect upon and cope with the perceived difficulties in the process of using the BTB programme. Participants

identified the absence of issues relevant to older people, the importance of continued therapeutic support and their struggle to cope with situations that prevented them from getting the most out of the BTB programme. The above themes were all seen to directly influence the lived experience of using the BTB programme which appeared to be one characterised by experiences of regaining control versus a sense of hopelessness. The inter-connections between the themes were bi-directional as it was hypothesised that the experience of change through using the BTB programme may influence the participants' ability to cope with and manage the perceived difficulties of using the BTB programme. Similarly it was recognised that if participants had difficulties using the BTB programme then this would impact their ability to make positive changes to facilitate their recovery.

The themes of "Motivation to Try Something New" and "Barriers to BTB at Time of Uptake" were also seen to directly influence decision-making processes leading to the uptake and/or discontinuation of the BTB programme. The theme of "Motivation to Try Something New" is significant to the completers and the discontinuers groups, representing participants' perception of hope in trying something new and having an opportunity to regain control through helping themselves and executing a choice in their treatment. Participants who had a greater sense of motivation to try something new were keen to initially engage with and continue with the programme. However, participants who were apprehensive about using computer technology and who were also experiencing significant life events at the time of being presented with the programme felt unable to cope with BTB and preferred to continue with alternative

treatment methods. The stages and relationships described above are represented in Figure 3.1.

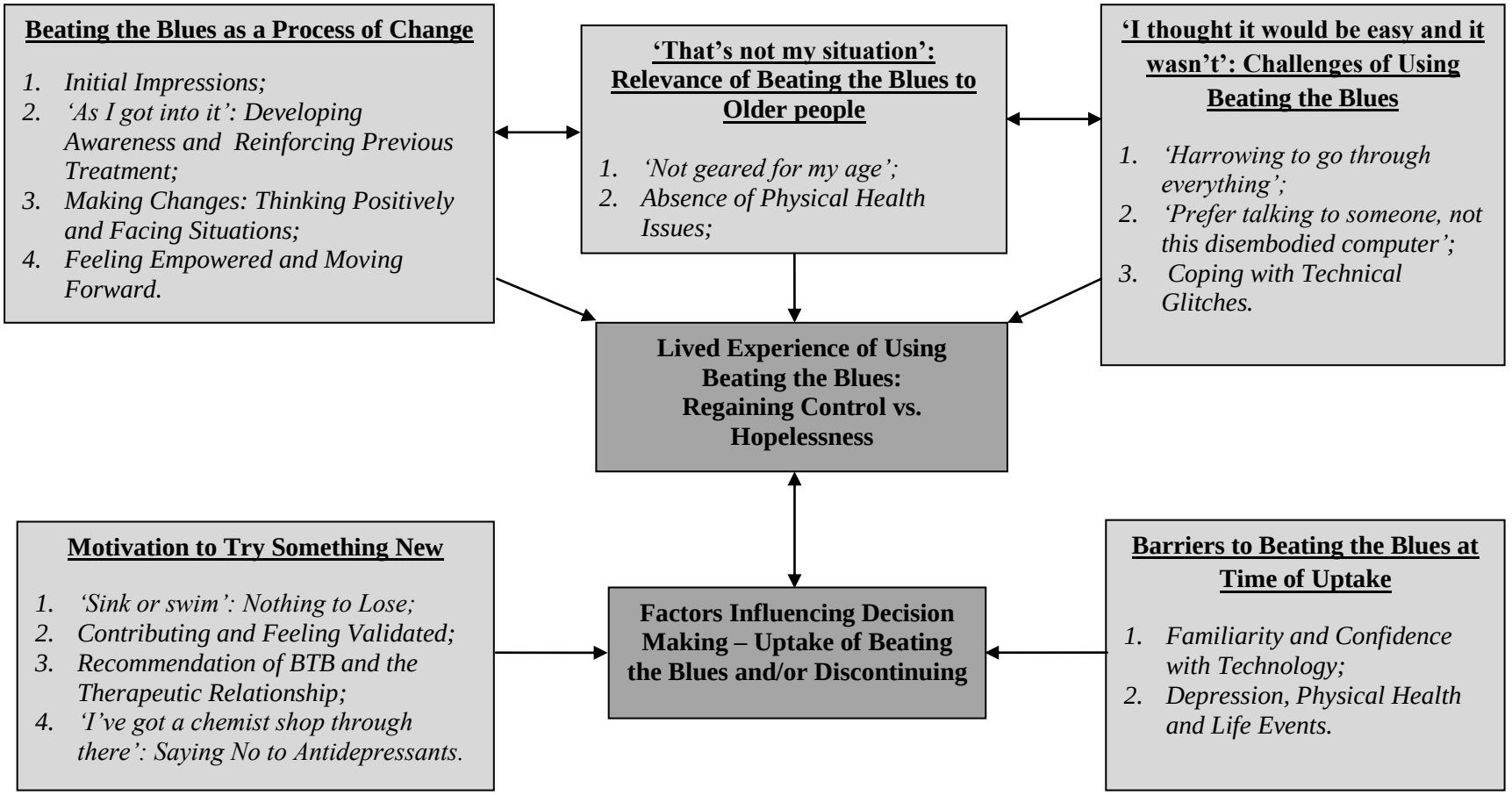

Figure 3.1: Diagram of Identified Master Themes and Sub-Themes of Participants' Experiences of Using the Beating the Blues Treatment and Factors that Influence Decision-Making

3.4 RESEARCHER'S PERSONAL REFLECTIONS

In IPA, there is a requirement for the researcher to take an interpretative stance when analysing participants' accounts. It is recognised that during this process the researcher may be influenced by their own preconceptions and experience. It is therefore recommended that researchers using IPA should take a reflexive position throughout the research process (Smith *et al.*, 2009). The researcher maintained a reflexive diary throughout the current study to document experiences and reactions to participant interviews, the process of transcribing and conducting the analysis. This process ensured the researcher was making her assumptions, experiences, knowledge and beliefs transparent. In order to mirror the language used within the reflexive diary, this section is written in the first person and extracts from this diary are discussed below.

The diary entry after my first day of interviews highlighted my anxiety about conducting qualitative research and my perceived challenges in doing these interviews. I found the first few interviews overwhelming for a couple of reasons. The interviews were very different from clinical sessions and I found myself constantly thinking of how I worded the questions, making sure to keep them open-ended so that participants' answers were not influenced in any way. The first few interviews were with participants in the discontinuers group; they were not as verbose as I hoped they would be and I felt I was using the prompts quite a lot. I also noticed their views of the BTB programme were quite negative and some of them continued to struggle with their difficulties and I found myself wondering why this might be.

> *"I did my first set of interviews today, and while I enjoyed doing them, I'm now feeling exhausted. It's hard to tell if I'm gathering enough detail of their experiences, but I don't think I could have prompted any more than I did, it felt like I was prompting too much. All three participants seemed to have negative experiences of the BTB programme. Why is that? Did they give the programme enough of the chance? Sometimes these things takes time…at least that's what I often say to patients of mine in my clinical work. Is this influencing how I interpret these interviews?" (Extract 1: 1st August, 2011)*

My fourth interview was with a participant in the completers group. I found my confidence growing during this interview as the participant spoke at length about their experience of using the programme. I started to feel as if I was settling into the process of doing qualitative interviews.

> *"I did my fourth interview today and I feel as though I might be getting the hang of them. It felt as if the interview flowed better and she had lots to say." (Extract 2: 5th August, 2011)*

As I progressed with doing interviews my confidence continued to grow and I was beginning to enjoy the interview process. I felt more able to reflect on participants' experiences and began detecting common themes which made me reflect on my clinical work.

> *"I'm half-way through interviews now. The relevance of the case examples to older people appears to be a common theme. This seems to be a negative experience for most of the participants raising it, but a couple of participants said they think age doesn't come into it. I found myself thinking of the clinical work I have done with older people and always holding their age in the back of my mind when conducting therapy. Should I have made more of an effort to assess if they felt their age was an important factor, rather than making assumptions?" (Extract 3: 19th September, 2011)*

The interviews with the TAU group happened later in the data collection process. I found my confidence with the interview process and doing qualitative research dropping when I started doing these interviews. The participants in this group had little to say in comparison to participants in the other two groups. Interviews were much shorter in duration and this made me anxious.

> *"I started TAU interviews today and I'm feeling really unsure about this group. The interviews were really short and participants had very little to say. Should I have included this group? Should I have asked different questions? What if no themes emerge from this group?" (Extract 4: 10th October, 2011)*

As I started my analysis, I thought about my sample size being relatively large but also consisting of three separate groups. I felt anxious about undertaking this part of the research process and whether I should analyse the groups separately or as one large group.

> *"I'm not sure whether I should analyse the groups separately or not. I've read studies doing both ways and both methods are feasible. I think with my data, if I were to analyse the groups separately, there would be themes only relevant to that group and not others…but maybe this is part of the whole story? Would I miss out important information of the overlap between the groups if I analysed them separately?"(Extract 5: 20th April, 2012)*

I discussed this particular concern with my supervisors and reached the decision to analyse the group as a whole as I felt it would represent the experiences of participants more fully. I felt quite overwhelmed with the amount of data that came from the interviews. I was worried that I would miss key experiences from

participant's accounts but at the same time was aware that I needed to maintain an interpretative stance.

> *"I'm feeling quite lost in all of the data. There is so much of it and I'm really worried I might miss some of the key themes. I feel I have this huge responsibility to capture what participants' are saying but find myself getting more and more anxious that I'll never be able to do this." (Extract 6:8th May, 2012)*

As I continued with my analysis, I found I settled into the process more and was able to see my data more clearly. Themes were starting emerge and I found it helpful to evaluate my interpretations through discussing them with my supervisors.

> *"I've started to see some common themes emerging in participants' interviews. I'm even seeing themes in the TAU interviews! I had a supervision session today and felt really good afterwards. I'm starting to feel a lot more confident in my interpretations and findings." (Extract 7: 21st May, 2012)*

In general, my anxiety throughout the whole research process is reflected in the entries in my reflexive diary. I was particularly anxious that I would not portray participants' experiences accurately. However, as I progressed through the research process, I developed more confidence and accepted that peoples' experiences tend to be complex and these cannot be manipulated so they all have the exact same interpretation. The complexities of their experiences will be reflected in my account, like they would in any other account.

3.5 PARTICIPANTS' REFLECTIONS

At the end of each interview, participants were asked to reflect on their experience of the interview process. All participants talked about the interview being a positive experience.

> *"...I enjoyed it, yeah it was very very useful for me, it makes me remember things about the programme, you know." (BTB047, BTB+TAU-Completer)*

> *"Oh, fine. As I say, I enjoy talking to people and flattered by having my views listened to. Somewhat challenged, made me think a bit." (BTB024, BTB+TAU-Completer)*

> *"Oh, it's been very good. Yeah, it is. It has been." (BTB005, BTB+TAU-Discontinuer)*

> *"It's quite pleasant. I like talking to people you know, that's what I miss." (BTB043, TAU)*

3.5.1 Respondent Validation

Respondent validation was sought after completion of the data analysis to review the credibility of the themes in relation to their experience. To do this, the researcher met with one participant from each group to present them with a summary of the findings (see Appendix 10). The researcher presented a summary of the master themes and sub-themes observed in the accounts of the overall sample. The specific themes relevant to each group category (completers, discontinuers or TAU) were also highlighted. For example, for TAU participants, only the fifth master theme was relevant as they did not use BTB.

All three participants expressed their agreement with the themes in general and the themes relevant to the group they belonged to.

"No, I think it covers it." (BTB029, BTB+TAU-Discontinuer)

"That first bit [first master theme] *definitely, I feel that's how it* [BTB] *helped me. That's how it personally helped me move on. It was definitely something you progressed through." (BTB047, BTB+TAU-Completer)*

Additionally, participants also recognised that some of the sub-themes did not relate to their specific experience, but could understand why they may have been raised.

"I never thought of physical illness right enough, maybe that would put you off." (BTB047, BTB+TAU-Completer)

"I could see how you would think that Beating the Blues would be better than taking medication, but you must want to do that. Maybe they were better at using a computer than I would have been." (BTB043, TAU)

"I hadn't thought about that [contributing to research] *but yes, that is there. In fact, my GP recommended me to take part in an Older Person's Advisory Group and I was really quite flattered to be involved in that." (BTB029, BTB+TAU-Discontinuer)*

Participant BTB043 also discussed feeling as though her fear of technology had been normalised in reviewing the results.

"It pretty much tells me there are more people in the world that are frightened of the same things I am." (BTB043, TAU)

The researcher is conscious that participants may have been reluctant to disagree with the researcher's findings in the feedback session. However, participants readily acknowledged the themes that did not fit with their situation, but did not discount them as potential themes for individuals within the other groups. Overall, the feedback from the three participants produced good support for the themes in the study and the researcher's interpretation of participants' decision making processes and experiences of using BTB.

CHAPTER 4 – DISCUSSION

4.1 SUMMARY OF RESULTS

The aim of the current study was to explore the lived experiences of older people using the Beating the Blues (BTB) computerised self-help programme and the aspects of this treatment that influenced engagement and recovery. The study also aimed to explore factors that influenced older people's decision-making processes in terms of uptake and discontinuation. Twenty older people who had participated in an earlier study by McMurchie (2011) took part in the current study. The sample comprised of individuals who undertook BTB and completed it (N=8), individuals who discontinued BTB prior to completion (N=5) and individuals who declined to use BTB altogether (N=7). Participants' age ranged from 67 to 84 years.

Transcripts were analysed together rather than as three separate groups as the researcher felt it would reveal both the convergent and divergent themes of the experiences of the overall sample. The analysis revealed five master themes that the researcher felt represented the decision-making processes and experiences of the overall sample. The first master theme "Beating the Blues as a Process of Change" related to participants' experience of change in their confidence and ability to cope with their depression through using BTB. This process represented a journey as participants' confidence levels and sense of coping improved the further they progressed through BTB. The second master theme '"That's not my situation': Relevance of Beating the Blues to Older People" represented participants'

perceptions of the suitability of BTB to older people. The third master theme '"I thought it would be easy and it wasn't': Challenges of Using Beating the Blues" represents the perceived difficulties of using BTB including finding it challenging due to their mood, a preference for face-to-face therapy and coping with technological difficulties. The fourth master theme "Motivation to Try Something New" relates to what participants felt influenced their decision to undertake BTB. The final master theme "Barriers to Beating the Blues at Time of Uptake" represents participants' reflections of factors that influenced their decision to not use BTB or to discontinue it prior to completion.

Overall, the master themes reflected the experiences of either "regaining control" or a sense of "hopelessness" when opting whether or not to use BTB in the first instance and to then continue with the treatment. The divergent feelings that arose when undertaking BTB appeared to be linked to the outlook participants had about using a novel treatment with either a sense of hope or impending failure. In participants who chose to undertake BTB, their outlook was hopeful and this impacted their ability to manage perceived challenges and influence their perception of change and work towards recovery. The sense of impending failure also seemed to be linked to participants perceiving more barriers to using BTB and struggling to overcome these challenges which resulted in them either declining BTB or feeling they were not benefitting from BTB and therefore discontinuing it.

4.2 REFLECTIONS ON MASTER THEMES

4.2.1 Beating the Blues as a Process of Change

Narratives in the current study indicate that participants who used BTB and progressed through to completion experienced a process of change. The earlier sessions of the programme were marked with initial uncertainty leading to increasing familiarity with the programme, the therapeutic style, content and assignments. Some participants discussed initially doubting their ability to use BTB, a novel and unfamiliar treatment. There was a sense of feeling 'too old' to learn new skills. This perception fits with the stereotype embodiment theory (SET) proposed by Levy (2009). The SET was formed after older people research demonstrated that 'both positive and negative age stereotypes can have beneficial and detrimental effects, respectively, on an array of cognitive- and physical-functioning outcomes' (Levy, 2009 p. 332). The theory states that age stereotypes become internalised from a young age and can operate unconsciously. As people age they undergo a process whereby they begin to identify themselves as 'old' and age stereotypes therefore gain salience from self-relevance and can have an impact on psychological, behavioural and physiological functioning (Levy, 2009). In terms of the current research, the negative age stereotype that participants were 'too old' to learn new skills, mirroring the belief that 'you can't teach an old dog new tricks' had a potential detrimental effect on participants' expectations of BTB and their ability to undertake it.

Narratives also suggested that some participants found the homework assignments of BTB burdensome at first, whereas others found them useful in terms of developing a

greater understanding of their depression. Similar findings have been demonstrated in previous qualitative research exploring the experiences of adults using the Colour Your Life (CYL) CCBT programme (Gerhards *et al.*, 2011), internet-based guided self-help (IGSH) (Bendelin *et al.*, 2011), BTB and MoodGYM CCBT programmes (Hind *et al.*, 2010) and online CBT (Beattie *et al.*, 2009). The current evidence is divided, with some participants experiencing the homework assignments as burdensome and an inconvenience (Bendelin *et al.*, 2011; Gerhards *et al.*, 2011; Hind *et al.*, 2010) and some perceiving the homework tasks as necessary to develop awareness (Gerhards *et al.*, 2011). Furthermore, it has also been demonstrated that participants found the content of CCBT helped them develop awareness of their depression and this had a positive impact on their thinking styles and behaviour patterns (Beattie *et al.*, 2009; Bendelin *et al.*, 2011).

The current study adds to the understanding of participants' experiences of using BTB whereby it offered a degree of freedom and flexibility in terms of how they applied aspects of BTB to their own circumstances. This appeared to be a positive experience for participants as it presented them with a sense of control in how they used BTB, enabling them to tailor the programme to meet their needs through selecting the components they experienced as beneficial. Similar findings were reported in the study by Gerhards *et al.* (2011) whereby participants experienced a sense of self-identification and improvement in their symptoms through appling aspects of the CYL CCBT programme to their own situation. This adaptive behaviour also fits with the selective optimisation with compensation (SOC) model of successful aging (Baltes & Baltes, 1990; Freund & Baltes, 2000; Riediger &

Lindenberger, 2006). The SOC model involves three components. 'Selection' refers to the adaptive process that older people engage in whereby they focus their resources on activities they perceive to be most rewarding that match their skills and situation, consequently producing a positive outcome (Coleman & O'Hanlon, 2008). 'Optimisation' refers to the ability older people have in adapting the environment to create favourable outcomes when facing challenges. The third component, 'compensation', refers to older people using alternative means to ensure their intended goal is reached (Coleman & O'Hanlon, 2008). In terms of the current study, participants selected aspects of the BTB programme that they felt related to their situation, and adapted the treatment to generate a desirable outcome, in this case, an improvement in their symptoms of depression. In line with previous research (Gerhards *et al.*, 2011), participants in the current study discussed the benefits of working through BTB at their own pace, developing a sense of 'discipline' through fitting BTB into their own schedule and developing a routine of when they completed sessions. In contrast, Bendelin *et al.* (2011) reported that participants perceived working at their own pace to be an obstacle to using IGSH and highlighted that face-to-face contact is more likely to provide this sense of 'discipline' which some participants felt was missing in IGSH. These findings suggest that participants who felt able to generalise the treatment programmes to their own circumstances found them more beneficial.

Perceptions of improvement in symptoms of depression were characterised in participants feeling they were thinking more positively and facing situations more proactively. All participants from the completers group reported BTB helped alter

their negative thinking styles and encouraged them to confront challenging situations. This led to participants feeling more self-sufficient, creating a sense of enablement and a positive self-image. This finding is consistent with previous research reporting that participants perceived working with the content of IGSH in a practical way to be a significant and positive experience as they were able to apply it to real-life situations and felt able to face difficult and challenging situations (Bendelin *et al.*, 2011).

Participants discussed developing a sense of autonomy and empowerment as a result of BTB. This involved experiencing a sense of accomplishment in overcoming depression, feeling able to cope with future potential challenges of everyday life and potential relapse and seeking support, from both BTB and their individual support network, if necessary. This finding is linked to recent evidence suggesting that older people demonstrate enhanced resilience and emotional regulation (Urry & Gross, 2010), whereby older people possess improved self-esteem, self-efficacy and problem-solving skills which enables them to remain positive during challenging situations (Windle *et al.*, 2008). Bendelin *et al.* (2011) reported that participants who experienced a change in their symptoms of depression were more able to overcome barriers through using the strategies learned from IGSH. Consistent with previous research (Bendelin *et al.*, 2011; Gerhards *et al.*, 2011), participants perceived a degree of support in the treatment programme itself, in that they were able to review completed materials and return to the previously completed sessions when faced with challenging situations. Furthermore, participants in the current study reported a sense of self-sufficiency as a result of BTB. This theme is also consistent with

McMellon and Schiffman's (2002) results that older people gained a sense of personal control and empowerment when engaging in online behavioural activities. These results fit with findings on self-help interventions that are described as empowering as they increase patients' skills and abilities to regain control of their life and face situations (Joling *et al.*, 2011).

4.2.2 'That's not my situation': Relevance of Beating the Blues to Older People

Participants highlighted the perception that BTB lacked content related to older people. Some participants discussed feeling unable to identify with the case examples presented in BTB and struggled to apply the content to their own situation as a result. This is consistent with the review by Crabb *et al.* (2012) that reported CCBT content appears to be oriented towards the needs of younger adults rather than older people. However, other participants felt that 'age' was not an issue and despite BTB lacking age-related content, they felt BTB can still be beneficial to older people. These participants appeared to be able to generalise the case materials to their own situation irrespective of the age of the case examples. It may also be the case that the experience of struggling to relate to the case examples is not just experienced by older people. For example, Gerhards *et al.* (2011) reported that participants in their study, who were adults of working age, felt unable to translate and apply the case example to their own situation as they were perceived as incomparable. For example, the solutions suggested by the case examples were incomparable to their own circumstances. This was perceived as a negative

experience and resulted in some individuals withdrawing from the Gerhards *et al.* (2011) study.

In the current study, participants also discussed the absence of physical health issues in the content of BTB. For some participants the need for inclusion of this issue was considered important as they perceived their physical ill health to interact with their depression. Similar findings were also demonstrated in the study by Hind *et al.* (2010) where participants felt that BTB did not acknowledge the interaction between depression and physical ill health. It is acknowledged that to improve outcome the CBT model may need to be contextualised in an age-appropriate frame of reference when working with older people (Laidlaw & McAlpine, 2008; Laidlaw *et al.*, 2004), given the presence of co-morbid medical conditions as well as issues of continuity and chronicity (Sadavoy, 2009). Therefore, it is likely that similar modifications to CCBT may also be of benefit when considering its utility with older people.

4.2.3 'I thought it would be easy and it wasn't': Challenges of Using Beating the Blues

In their experience of using BTB, participants spoke about the perceived challenges they encountered. For some, the challenge included BTB raising issues from their past which they did not want to revisit. This challenge resulted in their symptoms of depression deteriorating which was further impacted through not finding BTB helpful resulting in a sense of hopelessness and discontinuing from BTB. This finding is consistent with previous research where participants described perceiving

online CBT to be negative as they had to revisit issues they had already 'dealt' with (Beattie *et al.*, 2009) and participants felt 'lonely, shameful and disappointed' (p. 7) as there was a lack of treatment effect (Bendelin *et al.*, 2011). Furthermore, Bendelin *et al.* (2011) reported that participants who dropped out from treatment did so as a way of managing their difficulties.

In the current study, many participants expressed a desire for increased personal contact or a preference to speak to someone in person over BTB entirely. For some, personal contact represented a greater sense of support, a way of seeking reassurance and going into more detail on issues raised while doing BTB. However, for others, personal contact served to alleviate the sense of loneliness that can result when engaging in self-help interventions. The lack of personal contact was a contributing factor to some participants opting to discontinue BTB, while others were able to complete BTB despite missing it. This is consistent with previous research indicating that participants discussed missing human contact as it provided an opportunity for support and reassurance (Beattie *et al.*, 2009; Bendelin *et al.*, 2011; Gerhards *et al.*, 2011). Participants expressed that through adding face-to-face contact to CCBT they would be able to discuss their difficulties more in-depth, feel more able to overcome obstacles and their experience and motivation would improve (Bendelin *et al.*, 2011). Furthermore, the limited personal contact in IGSH led to participants expressing ambivalence and scepticism in managing their difficulties independently, thereby lacking in motivation and dropping out from treatment (Bendelin *et al.*, 2011). Hind *et al.* (2010) reported that participants felt CCBT increased their sense of social isolation. However, as demonstrated in the current

study, previous studies have indicated that while there is a sense of missing personal contact when undertaking CCBT, this did not necessarily impact treatment adherence (MacGregor *et al.*, 2009; Murray *et al.*, 2003; Waller & Gilbody, 2009). Consistent with previous research (Bendelin *et al.*, 2011), participants in the current study who perceived BTB to be unsuited to their needs also stated their belief that others could benefit from it.

In the current study, some participants felt they would be more able to develop a therapeutic relationship with a therapist rather than with a 'disembodied computer'. For some, this led to them discontinuing from BTB, however, others felt the audio presented in BTB did not seem artificial and thus enabled them to form a virtual therapeutic relationship with the programme. The divide in this experience suggests the mission of Proudfoot *et al.* (2003a) in developing BTB as a CCBT package that incorporated 'the non-specific factors implicit in the therapeutic relationship' (p. 279) was not experienced by all users of BTB. Beattie *et al.* (2009) discussed some participants expecting to experience doing therapy via a computer to be an 'odd, impersonal or mechanical relationship, like talking to a machine' (p. 50). Their findings indicated that some participants found it challenging to develop a therapeutic relationship, and these participants were more likely to withdraw from treatment. However, some participants were surprised at how easily they developed a therapeutic relationship and consequently found the intervention beneficial (Beattie *et al.*, 2009). A study exploring the development of a therapeutic relationship between participants and BTB (Omrod *et al.*, 2010) tentatively suggested that participants were able to form a therapeutic alliance with BTB and this was

experienced positively. These findings imply that the development of a therapeutic relationship with CCBT programmes creates a more positive experience, which may impact outcome. In relation to older people research, Hyer *et al.* (2004) described the value of the therapeutic alliance, an important component of the therapeutic relationship, in the application of CBT with older people and the positive impact this had on outcome. Similar findings have also been demonstrated in research with younger adults (Martin *et al.*, 2000; Stiles *et al.*, 2004). Therefore, if individuals, of all ages, are able to form a therapeutic alliance with a CCBT programme, this may influence treatment adherence and outcome.

Narratives in the current study indicated that one of the difficulties experienced by some participants related to challenges they experienced with technology. Participants described different coping strategies in dealing with these technological challenges. Some participants were able to use positive coping strategies in dealing with these difficulties including managing the situation independently, seeking support from family, or informing their professional contact associated with BTB. However, some participants felt unable to manage these technological difficulties and this resulted in feelings of distress and subsequently withdrawing from treatment. CCBT research indicated that participants expressed concerns regarding the computer failing, especially those who lacked confidence with technology (Hind *et al.*, 2010) and when experiencing technological difficulties this was perceived as frustrating (Gerhards *et al.*, 2011). In relation to older people using computers, accessing support through their family has been shown to be helpful (Angermeyer *et al.*, 2001) and the knowledge that technical support is available is perceived as

important (O'Brien *et al.*, 2008). This certainly appeared to be the case for some participants in the current study.

4.2.4 Motivation to Try Something New

Participants' narratives suggest there were various factors that motivated them to use BTB including viewing it as an opportunity in which they had 'nothing to lose'. Of particular importance was that participants wanted to be proactive in their self-care and took steps to help themselves. This theme was consistent with findings of previous research (Bendelin *et al.*, 2011; Elsegood & Powell, 2008; Joling *et al.*, 2011). In the study by Bendelin *et al.* (2011), participants using CCBT described valuing the independence IGSH offered them, enabling them to independently develop skills to help themselves and face situations. Similarly, Elsegood & Powell (2008) reported that participants, all of whom were older people, were enthusiastic about CCBT and perceived it as an opportunity to learn a new way of managing their difficulties.

In the current study, several participants discussed wanting to contribute towards research as a reason for using BTB. For some this served a purpose of 'giving back' and for others, contributing towards research provided a sense of validation. This theme is consistent with Erikson's concept of Generativity that is concerned with guiding the next generation through conducting socially-valued work and therefore contributing to society. In doing this, individuals gain a sense of productivity and accomplishment (McAdams, 2006; Slater, 2003). In the study by Hind *et al.* (2010),

some participants volunteered to participate not through help-seeking due to their depression but through wanting to help with research. The National Institute of Mental Health (NIMH) reported that people choose to participate in research for various reasons including wanting to assist professionals in developing better treatments and ways to help people, to learn more about their mental health problem and how to take care of it, and the positive experience of helping others through contributing towards the knowledge base (NIMH, 2009).

Of particular significance for participants in the current study was the recommendation of BTB by health-care professionals that participants felt they could trust. Furthermore, the way in which BTB was explained and demonstrated appeared to be important. Research has demonstrated that the acceptance of CCBT is enhanced when provided the opportunity to receive a demonstration of how it works (Cavanagh, 2010). Factors that motivated participants to use BTB included being able to complete sessions in the comfort of their own home, having a sense of privacy and having a degree of control in doing sessions in their own time and at their own pace. These findings are consistent with previous CCBT research in which participants viewed using CCBT in their home as a major advantage, stating it increased accessibility, provided a sense of anonymity, freedom and control (Beattie *et al.*, 2009; Gerhards *et al.*, 2011).

A significant motivating factor to using BTB for participants was that it provided an alternative to taking antidepressant medication. Some participants indicated a

preference for psychotherapy over medication, perceiving the side-effects of medication to be negative. This theme is consistent with previous research that has demonstrated that older people often prefer psychotherapy over pharmacotherapy (Arean & Cook, 2002; Arean *et al.*, 2001; Gum *et al.*, 2006; Laidlaw, in press), with concerns over side-effects, especially if experiencing co-morbid physical health issues (Anderson *et al.*, 2000; Gum *et al.*, 2006; Mendes de Leon *et al.*, 1998). Furthermore, being offered an alternative to medication to manage their depression and being able to opt for this alternative treatment option was viewed as a positive experience for participants in the current study as it promoted a sense of control. Research has demonstrated that older people can struggle to be assertive in health-care encounters (Ryan *et al.*, 2006). Therefore, older people may feel unable to assert their treatment preference during such encounters resulting in feelings of helplessness (Levy, 2003).

4.2.5 Barriers to Beating the Blues at Time of Uptake

In the current study, narratives of participants who opted not to use BTB indicated perceived barriers including a lack of confidence and experience in using computers. For some there was the perception they were too old to learn new skills, however, others had concerns regarding security of the computer programme or had no interest in using computers. This theme is consistent with general technology research exploring barriers to older people accessing internet technology, including feeling too old, lack of interest, fear of technology, perceived lack of experience and skills, security concerns, and problems associated with physical health and disability

(Morris & Brading, 2007). Furthermore, Beattie *et al.* (2009) suggested that computerised therapy may be harder for individuals who are less familiar with technology. Similarly, when approached about potentially utilising CCBT older people expressed fears of technology and being too old to learn new skills (Elsegood & Powell, 2008). Consistent with previous research, some participants in the current study experienced problems associated with their mental and physical health, for example a lack of motivation due to depression, difficulties with pain, fatigue and concentration (Elsegood & Powell, 2008; Hind *et al.*, 2010). Furthermore, similar to previous research these factors were perceived as barriers to accessing CCBT which influenced participants' decision to either decline CCBT entirely (Elsegood & Powell, 2008) or discontinue it prior to completion (Hind *et al.*, 2010).

4.3 METHODOLOGICAL CRITIQUE

4.3.1 Strengths

To the researcher's knowledge, this is the first study to qualitatively explore the decision-making processes and experiences of older people using the BTB programme. Hind *et al.* (2010) has been identified as the only other qualitative study that explored the acceptability of BTB and another CCBT package, MoodGym, to adults with depression and co-morbid physical ill health. This study included individuals who completed the entire CCBT package in addition to those who discontinued. However, it did not include the perspective of individuals who were offered CCBT but declined it. Elsegood and Powell (2008) conducted a small survey-based study that demonstrated that older people may be willing to engage

with CCBT and learn the necessary skills. This study provided preliminary findings on factors that may influence older people's decision to use CCBT; however, it did not recruit participants to use CCBT in order to explore their experiences of using it.

Theoretical sampling techniques were used in the current study to recruit a total of twenty participants. The overall sample included individuals who completed all eight sessions of BTB (N=8), individuals who discontinued BTB prior to completion (N=5) and individuals who declined to undertake BTB when offered it (N=7). The inclusion of multiple perspectives provided in-depth accounts on both the motivational factors and the perceived barriers to undertake BTB. Furthermore, the inclusion of both completers and discontinuers provided accounts that were characterised by comparisons of satisfaction and regret in undertaking BTB. The current study enhances the understanding of the factors that influence the decision-making processes of older people when choosing to use or not use BTB and when making the choice to discontinue from BTB. Therefore, the findings of the current study may inform services of the potential barriers to BTB that may help clinicians to identify methods to promote uptake and increase engagement, as well as providing improved understanding of those individuals who are less likely to respond to this mode of psychotherapy.

The current study also adds to the understanding of the process of change experienced while progressing through the BTB programme. This finding has been demonstrated in previous research (Gerhards *et al.*, 2011) but has not explicitly been

perceived as a process of change. Participants in the current study drew attention to the complex process of change as they progressed through using BTB. This 'change' suggests that participants perceived they were more able to cope with their depression whereby they gained a greater sense of positive self-image and experienced improvement in their symptoms, which influenced their motivation to adhere to the programme.

The complex and conflicting nature of participants' accounts detailed in the current study was achieved through using qualitative methodology. It is unlikely that such nuances would have been captured if using a quantitative approach alone. Steps to enhance the methodological rigour were completed by the researcher, including enlisting multiple reviewers to check for corroboration and concordance of themes, completion of respondent validation and keeping a reflexive diary. Furthermore, examples of quotes and summaries of themes were provided as further evidence of the analysis.

4.3.2 Limitations

There are a number of limitations to the current study. The current study employed a retrospective design whereby participants were asked to recall their experiences of using BTB and their perception of the factors influenced their decision-making processes. This raises the risk of participants inaccurately recalling information of their experiences and perceptions as a result of recall bias, which may be influenced by their current emotional state as former users of BTB. Participants were

recruited following completion of the pilot outcome study by McMurchie (2011) and there was an interim of at least a few months for many participants between completion of the pilot outcome study and their interview. To avoid this potential limitation, future studies exploring the acceptability and experiences of individuals undertaking a treatment intervention like CCBT should be conducted simultaneously to studies examining the effectiveness of the treatment intervention.

The age of participants recruited in the current study ranged from 67 to 84 years (mean age = 74 years). There were therefore no participants from the oldest old age category (85 years and over) included in the sample. The under-representation of oldest old people is frequently seen in older people research (Cuijpers *et al.*, 2009; Scogin *et al.*, 2005). It therefore remains unclear if the findings of the current study reflect the perceptions of older people from the older old age category. Thus the researcher is aware that caution is required in generalising the findings of the current study to older people who are aged 85 years and over.

Participants were recruited during their follow-up appointments when participating in pilot outcome study (McMurchie, 2011). There is a possibility that participants may have viewed the researchers of both the pilot outcome and the current study to be invested in the BTB programme and therefore feeling unable to discuss any negative experiences they had with BTB. However, given the interviews had detailed descriptions of both positive and negative experiences of BTB suggests that this did not occur. The researcher also attempted to reduce this potential bias by

informing participants in the Participant Information Sheet that the researchers had no personal vested interests in the BTB programme.

The researcher acknowledges that participants' accounts may have been influenced by previous treatment experience. Many of the participants who used BTB had received previous psychological treatment. The researcher took steps to orientate participants during the interview through specifically asking about their experiences of using BTB as opposed to their experiences of undertaking another form of psychological intervention. If and when participants discussed their previous treatment experiences, the researcher attempted to re-focus their accounts to BTB by asking how this treatment experience compared to their experience with BTB.

There is also the potential impact of sequential analysis during data collection and analysis of the current study. Miles and Huberman (1994) discuss the possibility that researchers can be prone to bias through attaching more weight to specific participant accounts, for instance participants who are more 'articulate and reflective and may enjoy talking about events and processes' (p. 268). Furthermore, Miles and Huberman (1994) state that the nature of the data collection process means that a primacy effect can occur whereby more strength may be attached to participant accounts collected earlier or first in the process which in turn may influence subsequent interviews or analysis that follows. In the current study, participants BTB037 and BTB047 provided more detailed and descriptive accounts of their experience of using BTB. These participants were also interviewed and their

transcripts were analysed earlier in the research process. The researcher attempted to omit bias through returning to earlier transcripts to search for themes identified in later transcripts, searching for negative cases, making an effort to use other participant's narratives and using their reflexive diary. Despite these efforts, it is possible that these earlier narratives may have influenced the analysis of subsequent accounts.

Another potential limitation was the researcher's choice to analyse participants' transcripts together as opposed to analysing them separately as three groups. Previous qualitative research involving separate groups of participants, for example, completers and discontinuers, carer and recipient or parent and child have analysed the groups together (Federici & Kaplan, 2008; Griffiths, 2009) and separately (Jones *et al.*, 2008; Wilkinson, 2010). While the researcher felt that analysing the transcripts as a whole would help provide a richer account of both the convergent and divergent experiences of all the participants, there is potential that through aggregating the data some of the richness of the data belonging to each individual group may be lost.

4.4 IMPLICATIONS FOR SERVICE PROVISION

Based on the discussion with participants and the emergent themes in the current study, there are a number of implications for clinical practice and service provision of older people's psychological therapies services.

In the current study, some participants raised the lack of age-related information included in the BTB programme. For some participants, the perceived lack of age-related information resulted in a level of dissatisfaction with the content of the programme or influenced their decision to stop using BTB altogether. There have been suggestions that psychological interventions, including CBT, need to be culturally specific and appropriate for the populations they are applied to. As such taking account the age-appropriate context in which to understand the individual and their experiences is what is proposed for CBT with older people. (Laidlaw, 2010). Therefore, it is important that CCBT is examined in this way with older people to make it more specifically appropriate with this cohort. In the current study, some participants raised the issue that the case examples were not comparable to their own situation and thus struggled to translate and apply the solutions to themselves. Furthermore, some participants highlighted the absence of physical health issues, for example, arthritis. It is understood that the prevalence of physical health issues increases with age and that there is a strong association between depression and co-morbid physical health conditions (ONS, 2009). The current study emphasises the need for these issues to be taken into account when considering optimising older people's engagement with the BTB programme, as with any psychological intervention.

In analysing participant's narratives, the importance of both knowing support is available to them and practically receiving support played a significant role in

motivating them to engage with BTB and adhering to it. When considering older people for CCBT it may be that they require an additional level of support in relation to the technological and therapeutic aspects of CCBT. However, it appears that having some level of support both mid-way through the programme and at the end may be beneficial and would perhaps improve engagement and adherence.

Furthermore, participants also discussed the process of being introduced to the BTB programme as valuable. This included a detailed explanation and demonstration of BTB prior to using it. Participants stated this motivated them to engage with BTB as they perceived the recommendation to come from a credible source and the demonstration gave them insight into what to expect from BTB. The demonstration provided in the pilot outcome study (McMurchie, 2011) does not reflect what occurs in routine clinical practice, for both younger adults and older people, as individuals are usually referred by their GP. Therefore, services may wish to consider the value of providing a demonstration of BTB when referring individuals to enhance engagement.

Some participants raised the perception that BTB would be more suited to individuals who were experiencing their first episode of depression or experiencing mild symptoms of depression. This perception is in line with the model of matched care suggested in the treatment guidelines (NICE, 2006; SIGN, 2010) and proposed by Wells *et al.* (2010) and the OPPTWG (2012). This finding indicates the importance of assessing the suitability of individuals for BTB prior to referring them.

This may help prevent feelings of failure and hopelessness associated with a lack of treatment effect.

Older people's psychology services have been shown to be significantly under-resourced (ISD, 2012). The use of low-intensity interventions would help increase access to psychological therapies. Low-intensity interventions such as self-help material and guided self-help have shown to be effective with older people (OPPTWG, 2011). Older people have been under-represented in CCBT research (Crabb *et al.*, 2012) and recently a study solely with older people has demonstrated the potential utility of CCBT in treating symptoms of depression and anxiety (McMurchie, 2011). CCBT fits within a matched-care model as advocated by both NICE (NICE, 2006) and SIGN (SIGN, 2010) guidelines in the management of depression. Offering CCBT as part of a matched-care model in older people's psychological therapies services may become part of a range of options to improve access to psychological therapies. Furthermore, the Equality Act 2010 (GEO, 2010) advocates services offering services on the basis of needs as opposed to age. CCBT is currently widely utilised within adult services but less frequently in older people services. One reason for this may be due to the assumption that older people would find computer usage unacceptable (Kaltenthaler *et al.*, 2004b). Such negative age stereotypes fit with the discrimination witnessed in mental health services (RCPsych, 2009). However, technology research has demonstrated that older people can and do use computers (Randall, 2010; Shapira *et al.*, 2007). Therefore, to fit with the aims of the Equality Act, if older people present with needs that can be appropriately met

by CCBT, whether or not this is available in their specific service, they should be granted the opportunity to undertake it.

4.5 POSSIBILITIES FOR FUTURE RESEARCH

As discussed above, the current study carried out the interviews retrospectively, for many participants this was a few months after they had completed their participation in the pilot outcome study by McMurchie (2011). It is possible that changes in symptoms occurred during this delay which may alter participants' recollections of using BTB or their reasons for not using it. For more accurate recall, future research could employ joint quantitative and qualitative studies conducted simultaneously so that participants' experiences can be explored as and when they are using the BTB programme and immediately after completion. Furthermore, for participants who decline BTB, their decision-making processes can be explored immediately afterwards.

The current study explored the experiences of older people using the BTB CCBT package. As there are many CCBT packages available which are utilised across the UK, future research may wish to explore the experiences of older people using CCBT packages other than BTB. Furthermore, there is a need for good-quality comparative studies, with both adults of working age and older people, to indicate which CCBT packages are superior in terms of uptake, acceptability and effectiveness.

A recent doctoral thesis on clinicians' attitudes towards CCBT in adult mental health (Varley, 2011) concluded that while there is moderate interest in using CCBT amongst clinicians, doubts over the effectiveness and acceptability or unacceptability of CCBT remain. Results indicated that clinicians perceived the lack of human contact to be a key factor in the acceptability of CCBT and therefore feel a more robust evidence-base is required before increasing their referrals to it (Varley, 2011). A similar study exploring the attitudes of multi-disciplinary clinicians in older people's services is warranted. Anecdotal evidence suggests that clinicians' referring older people to CCBT assume they are less likely to engage with this form of therapy, will struggle with the technological aspects and will therefore drop-out (Crabb *et al.*, 2012). Such attitudes seem unfounded, especially given what recent research has demonstrated (Elsegood & Powell, 2008; McMurchie, 2011), and creates barriers to older people accessing an evidenced-based psychological intervention. A deeper understanding of clinicians' attitudes could lead to staff training initiatives with the aim of reducing these barriers and increasing referrals of older people to CCBT. However, it is important to note that research should not focus solely on the attitudes of clinicians, but of all health-care professionals working with older people who are potential gatekeepers to referring them to CCBT.

Further to the study by Hind *et al.* (2010), additional research on the acceptability of CCBT for people with depression and other co-morbid physical health problems, for example, stroke, heart disease and arthritis is warranted particularly with older people as they often present with co-morbid physical health issues. There is also scope for exploring the acceptability of CCBT with caregivers, many of who are

aged 65 years and over and are at an increased risk of developing psychological difficulties (Brodaty, 2002). Furthermore, there is potential for future research to examine the acceptability of CCBT for older people with depression who reside in care homes. Following the outcomes of the McMurchie (2011) and the current study, research is being undertaken to investigate developing a 'gold standard' model for the roll out of BTB with older people.

The current study is the first to explore the experiences of older people using BTB and the findings may only reflect the experiences of older people. To the researcher's knowledge, the only other study exploring the experience of users of BTB was conducted by Hind *et al.* (2010) with depressed adults with co-morbid multiple sclerosis (MS). There does not appear to be a similar study with adults of working age. Therefore, a replication of the current study with adults of working age is warranted and will reveal if the findings of the current study are specific to the older people population or if similar findings are demonstrated with adults. There are currently plans underway to replicate the current study with adults of working age to explore if their experiences are similar or dissimilar to the experiences of older people.

4.6 CONCLUSION

The current study has generated insight into the decision-making processes of older people when being offered the BTB programme and the experiences of older people who used it. This contribution to the existing literature on BTB and CCBT overall is

important given the lack of research exploring the experiences of CCBT users in addition to the limited CCBT research including older people. The findings suggest that depending on the outlook individuals had when being offered BTB, this resulted in them either feeling motivated to try a novel treatment, perceiving it as an opportunity to regain control and learn new skills or feeling uncertain about the treatment, perceiving barriers to successfully undertaking it and doubting that they would benefit from it. There appears to be a tension between participants' experiences when using BTB. Some participants felt empowered by being offered something new that offered strategies for dealing with their depression, while other participants felt BTB did not meet their needs for someone to listen to them and understand the impact of aging, physical ill health and depression. The perception that support, both therapeutic and technical, and reassurance was available if necessary seemed to be important in promoting adherence and helping participants overcome perceived challenges while using BTB resulting in more positive experiences. The current study has therefore met a significant gap in the evidence-base and has clear implications for clinical practice and service development.

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APPENDICES

APPENDIX 1

Letter of NHS Ethics Committee approval

NHS Fife | NHS Forth Valley | NHS Tayside

East of Scotland Research Ethics Service

Tayside Committee on Medical Research Ethics B
Research Ethics Office
TAHSC, Residency Block C
Ninewells Hospital & Medical School
DUNDEE
DD1 9SY

Mr William McMurchie
Sunnyside Royal Hospital
Clinical Psychology Department
Booth House
Montrose
DD10 9JP

Date: 26 April 2011
Your Ref:
Our Ref: LR/10/S1402/36
Enquiries to: Mrs Lorraine Reilly
Extension: Ninewells extension 40099
Direct Line: 01382 740099
Email: Lorraine.reilly@nhs.net

Dear Mr McMurchie

Full title of study: **Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression and Anxiety in Older People**
REC reference number: **10/S1402/36**
Protocol number: **N/A**
Amendment number: **AM01**
Amendment date: **21 April 2011**

The above amendment was reviewed at the meeting of the Sub-Committee held on 25 April 2011.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation and condition below:

- The Committee requested that an opt-in slip should be attached to the Participant Information Sheet so the participant can send it back to the researcher if they wish to take part in the study or not.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
CV - Melissa Hanna		21 April 2011
Flowchart	1	05 April 2011
Interview Schedules/Topic Guides	1	29 March 2011
GP/Consultant Information Sheets	1	27 March 2011
Participant Consent Form: 2	1	27 March 2011
Participant Consent Form: 1	1	27 March 2011
Participant Information Sheet	1	27 March 2011

Notice of Substantial Amendment (non-CTIMPs)	AM01	21 April 2011
Covering Letter		21 April 2011

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/S1402/36	**Please quote this number on all correspondence**

Yours sincerely

for **Mrs Sandra Forbes**
Chair

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Fiona Sloan, University of Edinburgh
NHS Tayside R&D office
Melissa Hanna, Trainee Clinical Psychologist, Sunnyside Royal Hospital

APPENDIX 2

Letter of Research and Development approval

NHS
Tayside

16 June 2011

Mr William McMurchie
Trainee Clinical Psychologist
Sunnyside Royal Hospital
Clinical Psychology Department
Booth House
MONTROSE
DD10 9JP

Dear Mr McMurchie,

ACCEPTANCE OF AMENDMENT LETTER

Title: Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression and Anxiety in Older People (Original study).
Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression and Anxiety in Older People: Perceptions of Older People of Decision Making and Treatment (Sub-study).

Chief Investigator: Mr William McMurchie **Principal Investigator: Miss Melissa Hanna**

Tayside Ref: 2010PZ02 **NRS Ref: N/A**

REC Ref: 10/S1402/36

EudraCT Ref: N/A **CTA Ref: N/A**

Sponsor: University of Edinburgh

Funder: Unfunded

Amendment Number: 01 **Amendment Date: 21/04/11**

Thank you for submitting the above amendment for review by the R&D Office here in NHS Tayside. Following my assessment of the proposed changes I am pleased to confirm that NHS Tayside has no objection to these being implemented locally.

Approved Documents

Document	Version	Date
Letter from Ethics – Favourable Ethical Opinion of Amendment		26/04/11
Letter from Ethics – Evidence of Compliance		09/05/11
Letter from Ethics – Evidence of Compliance		26/05/11
CV – Melissa Hanna		21/04/11

Flowchart	**1**	**05/04/11**
PIS	**2**	**09/05/11**
Consent Form	**3**	**26/05/11**
Opt-in Form	**3**	**26/05/11**
GP Letter	**1**	**27/03/11**
Interview Schedule	**1**	**29/03/11**

I thank you for keeping the R&D Office informed of the study progress.

Please note all minor/substantial amendments and end of trial notifications must be reported to the R&D Office.

Yours Sincerely

Elizabeth Coote
R&D Manager

TAyside medical Science Centre (TASC)
Ninewells Hospital & Medical School
TASC Research & Development Office
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c.c. Miss Melissa Hanna
Tayside Committee on Medical Research B
Sponsor Representative – Ms Fiona Sloan

APPENDIX 3

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older people: Perceptions of Older People of Decision Making and Treatment.

INVITATION

My name is Melissa Hanna. I am undertaking a doctoral training course in Clinical Psychology at the University of Edinburgh. I am required to undertake a project as part of my course and invite you to take part in the following study. However, before you decide whether or not you wish to participate, I need to be sure that you understand firstly why I am undertaking the project, and secondly what it would involve if you agreed to participate. I am therefore providing you with the following information. Please read it carefully and be sure to ask any questions you have, and if you want, discuss it with others including friends and family. I will do my best to explain and to provide any further information you may ask now or later.

It is important that you know that you do not have to make an immediate decision about taking part in the study and you can take the information away before you decide.

Background to the study
You have recently completed taking part in the study Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older People. The current study aims to explore the decision making and experiences of treatment of people who have taken part in the study to gain a better understanding of whether the programme is acceptable to older people (those above the age of 65 years) in treating depression and anxiety.

Purpose of this study
The purpose of the study is to explore the decision making and experiences of treatment of people who have taken part in the study Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older People. The study is also being written up as the Principle Investigators doctoral thesis at the University of Edinburgh, who are sponsoring the study. It is intended this study will be submitted for publication in a scientific journal and will help inform others about how acceptable Beating the Blues is with older people.

Why have I been asked to take part in the study?
You have been asked to take part in the study as you have recently completed taking part in the study Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older People. The Chief Investigator of this study felt you may want the opportunity to discuss your reasons for your treatment choice and your experiences of this treatment.

Do I have to take part?
No, you do not have to take part in the study. We will provide you with information and answer any questions and it is then entirely up to you if you want to take part. **You are free not to take part or withdraw from the study at any time and you do not have to give a reason for this.** If you decide not to take part or withdraw from the study this will not affect any treatment you currently receive or any treatment you may receive in the future.

What is involved at this stage?
If you are interested in possibly participating, the next step includes you completing the Opt-In Form to allow your contact details to be provided to the Principle Investigator. The Principle Investigator will then contact you and, if you agree, will arrange for you to meet. At this meeting you have all information about taking part clarified before deciding whether or not you wish to participate. **By signing the Opt-In Form you are not agreeing to take part in the study, but you are just agreeing to be contacted to find out more information.**

What is involved if I take part?
At the end of your meeting with the Principle Investigator you will be asked to indicate whether or not you wish to take part in the study. If you choose to participate, you will be asked to sign the Consent Form. Following this, you will meet with the Principle Investigator on one occasion for an interview to discuss your decision making and experiences of treatment when taking part in the study Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older People. The interview is expected to last no longer than 60 minutes. I would like to audiotape the interview for better recall and analysis of the information you provide. However, if you do not wish the interview to be recorded, please let me know about your wishes and I will only keep notes.

I will be happy to provide breaks at any point within the interview should you feel upset or tired.

Where will the initial appointment and interview happen?
Both the initial appointment and interview can take place in either your own home or in one of the outpatient departments within NHS Tayside. Specific details about these locations will be provided when you are contacted and you can choose which is the most convenient. If you attend an NHS Tayside location, you may be eligible to have your travel expenses reimbursed in line with NHS Tayside policy. Full details of this will be provided at your initial meeting with the Principle Investigator.

What will happen if I want to withdraw from the study?
Your participation in the study is entirely voluntary and you are free to withdraw at anytime without giving a reason. By choosing to withdraw, your current and future treatment would in no way be affected if you withdraw.

Will my taking part be kept confidential?
As in the first study, all information you provide will be kept confidential and any personal information will be made anonymous. It is common practice for your GP to be informed of your participation. During your participation, if you indicate that you or another person are at risk of harm, confidentiality would have to breached and clinical staff will be informed so you can be provided with the appropriate support.

Who has reviewed the study?
The Tayside Committee on Medical Research Ethics, which has responsibility for scrutinising all proposals for medical research on humans in Tayside, has reviewed the proposal and raised no objections from the point of view of medical ethics. It is a requirement that your records in this research, together with any medical records, be made available for scrutiny by monitors from the University of Edinburgh and NHS Tayside, whose role it is to check that research is properly conducted and the interests of those taking part are adequately protected.

What are the possible advantages/disadvantages associated with taking part in the study?
People can find such interviews to be a positive experience as they feel listened to. However, you may find it upsetting if you decide to discuss experiences that may have been difficult for you. If you do feel upset, I will stop the interview for a break or to reschedule. You may also decide at this point that you wish to withdraw from the study. Additional support will be available from clinical staff involved in your normal, routine care should you feel you would benefit from an opportunity to discuss any issues further.

Information we get from this study will help us better understand the decision process involved in why people choose / do not choose Beating the Blues treatment and the views of people receiving treatment from the Beating the Blues Computerised Cognitive Behaviour Therapy programme. We hope that the findings of the study will contribute positively to better treatment and care for older people with depression and anxiety in the future. The results of the study are likely to be published so that its findings can be used across the United Kingdom, however, you will not be identified in any report or publication.

What should I do if there are any problems?
If you have any problems regarding taking part in the study we would advise you to immediately contact the Principle Investigator of the study (contact details provided overleaf).

If you have a concern about any aspect of the study or the way you have been treated we would advise you to contact the Principle Investigator or the Clinical Supervisor (contact details provided overleaf) in the first instance who will do their best to address any concerns you have. You may also wish to speak to a clinician for independent advice and the contact details for an Independent Advisor are also provided overleaf.

If you remain unhappy and wish to complain formally, you can do so to the following:

Complaints and Claims Manager
Complaints and Advice Team
Level 7
Ninewells Hospital
Dundee
DD1 9SY
Freephone: 0800 027 5507
Email: complaints.tayside@nhs.net

What will happen after the study ends?
During and after you complete the study you will continue to receive your treatment as usual i.e. whatever you have already been receiving as part of your normal, routine care. At the end of the study, you can be provided with a written summary of the overall results of the study if you so wish.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

CONTACT DETAILS

Should you wish to discuss any aspect of the study, please contact:

Melissa Hanna
Principle Investigator
Trainee Clinical Psychologist
NHS Tayside Older People's Psychological Therapies Service
Booth House, Sunnyside Royal Hospital
Montrose
01674 832259

Or

Dr Fiona Macleod
Clinical Supervisor
Consultant Clinical Psychologist
NHS Tayside Older People's Psychological Therapies Service
Booth House, Sunnyside Royal Hospital
Montrose
01674 832259

For independent advice on participating in this specific study or research in general, please contact:

Mrs Alison Peaker
Independent Advisor
Consultant Clinical Psychologist
NHS Tayside Adult Psychological Therapies Service
Booth House, Sunnyside Royal Hospital
Montrose
01674 832251

APPENDIX 4

Consent Form

CONSENT FORM

Study Title: Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older people: Perceptions of Older People of Decision Making and Treatment.

1	I confirm that I have read and understood the Participant Information Sheet dated 9/5/2011 (Version 2) for the above named study. I have also met with Principle Investigator who has clarified these details. I have had the opportunity to consider all the information, ask questions and have had these answered satisfactorily.	
2	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any current or future medical care or legal rights being affected	
3	I agree that my G.P will be informed of my participation in the study.	
4	I understand that any information I provide whilst taking part in the study will be kept confidential. However, I understand that should any information I provide indicate either myself or another is at risk of coming to harm, confidentiality will be broken and the relevant individual in my care team informed.	
5	I understand that the interview will be recorded to ensure better recall and analysis of the information provided. I understand that I can request the interview not be recorded if I so wish.	
6	I understand that relevant sections of my research notes and data collected during the study may be looked at by individuals from the university of Edinburgh or from NHS Tayside, where it is relevant to my taking part in this research. I give permission for these people to have access to my research records.	
7	I agree to participate in the study	

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

Please provide the following details so your GP can be contacted regarding your participation in the study:

GP Name:……

GP Practice:……

……

……

APPENDIX 5

Opt-in Form

OPT-IN FORM

Study Title: Beating the Blues: Computerised Cognitive Behaviour Therapy for Depression & Anxiety in Older people: Perceptions of Older People of Decision Making and Treatment.

Date:.....

Participant code:.....

		Please Initial
1	I confirm that I have read and understood the Participant Information Sheet dated 9/5/2011 (Version 2) for the above named study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2	I agree to have my contact details (please provide overleaf) passed on to the Principle Investigator for the above named study. I agree I can be contacted to confirm if I am still interested in participating and if so to meet with the Principle Investigator to find out more information.	
3	I understand that by signing this opt-in form and agreeing to meet with the Principle Investigator of the research team I am not agreeing to take part in the study. I understand my participation in the study is voluntary and that I am free to withdraw at any time without giving any reasons, without any medical care of legal rights being affected.	

Name of participant	Date	Signature
Name of person taking consent	Date	Signature

CONTACT DETAILS

Please provide details you are happy to be contacted on:

Home telephone number:.....

Mobile telephone number:.....

Address:.....

.....

.....

.....

THANK YOU FOR COMPLETING THIS FORM

APPENDIX 6

Interview Schedule

Interview Schedule

Group 1: BTB+TAU-Completers

Experience of Intervention (BTB)

1. Can you summarise your experience of using BTB?
    a. (Prompt) What was it like to use? How did you feel about using a computer?
    b. (Prompt) What was helpful/unhelpful about the programme?
    c. (Prompt) Can you tell me how this treatment programme has affected you/your recovery/symptoms, if at all?
    d. (Prompt) How did you find the content and pace of the programme?
    e. (Prompt) How did you feel about using it at the start? What are your views now?
    f. (Prompt) Is there anything that you think would have improved your experience of this treatment?

Decision Making Process

1. Can you tell me how you decided you wanted / did not want to use BTB?
    a. (Prompt) Why did this treatment choice appeal to you? Why did the other treatment choice not appeal to you? (remaining with TAU)

Group 2: BTB+TAU-Discontinuers

Experience of BTB

1. Can you summarise your experience of using BTB?
    a. (Prompt) What was it like to use? How did you feel about using a computer?
    b. (Prompt) What was helpful/unhelpful about the programme?
    c. (Prompt) Can you tell me how this treatment programme has affected you/your recovery/symptoms, if at all?
    d. (Prompt) How did you find the content and pace of the programme?
    e. (Prompt) How did you feel about using it at the start? What are your views now?

f. (Prompt) Is there anything that you think would have improved your experience of this treatment?

g. (Additional Prompt) What do you think contributed to your decision to stop using BTB at that stage?

Decision Making Process

1. Can you tell me how you decided you wanted / did not want to use BTB?

    a. (Prompt) Why did this treatment choice appeal to you? Why did the other treatment choice not appeal to you? (remaining with TAU)

<u>Group 3: TAU</u>

Decision Making Process

1. Can you tell me how you decided that you did not want to use BTB?

    a. (Prompt) Why did this treatment choice appeal to you? Why did the other treatment choice (BTB) not appeal to you?

    b. (Prompt) How did you feel about potentially using BTB? What concerns did you have about using it, if any?

Closure of Interview:

1. Is there anything you would like to share with me, but did not have the chance in the previous questions?

2. How was the experience of this interview for you?

Additional Prompts:

- I'm interested in / can you tell me more about that?
- What do you mean by that?
- What would be an example of that?
- What did you do?
- How do you feel about that?
- What do you think about that?
- What were your thoughts then?

APPENDIX 7

Excerpt from coded transcript

(Participant BTB047)

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
Flexibility and control in using BTB Reinforcing previous treatment / developing awareness	I: Could summarise your experience of using Beating the Blues? R: I found it helpful, it was different in, from the actual classes I did at the, some years ago at [place] for cognitive behavioural therapy, with the advantage of that you could go back and go over something again if it was particularly relevant. Whereas sometimes obviously if you're in a class you just get carried on with the class if you don't make a point yourself. Or if somebody makes a point and you know, it goes on, you know the thing gets diverted to their point, their view. But I found it relevant to the fact it was for *you* personally and not for anybody else and you could do it your own way. I'm trying to...there were things that of course I recognised from previous things, you know, the things the way your mind words, you kind of get into behavioural patterns that are wrong and how to get out of them, that was, I think that's the main of thing of it, that being cognitive behavioural therapy, because of that and I found it helpful, I did, because you could put in your own personal bits that you're worried about and it would follow up every week on it, that was good. And there were	Helpful Previous treatment – different Focus on relevant bits **BTB = feel more in control** Class = different BTB is for you, *emphasis on 'you'* Your own way **Control** Previous treatment – similar **Reinforcing previous knowledge –empowerment** Helpful Make BTB your own Follow-up **Support**

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
	things you had to carry on with as well.	
	I: So can you tell me what it was like to use?	BTB is easy; *emphasis on 'easy'*
Recommendation of BTB	R: As a programme? (I: hmm-mm) I found it *easy*, really it was, it was no problem but as I say, if you made a mistake I think it was easy to, it prompted you in all the right places. As I say, when [name of referrer] came to, came, he explained to me you can go over it, you can go back any time and you could, you know, and he explained to me they ask all the relevant questions about suicide and all that, he said that will always happen. So I wasn't shocked by it or anything like that. But I found really very very easy to use, really. It was I wouldn't say I was terrific with a computer but I am quite good, you know. I can work it quite well, I found it no problem.	Demonstration of BTB **Selling BTB; motivation to try it**
Familiarity with technology		BTB easy
		Familiarity with computers
	I: And how did you feel about using a computer?	
	R: Fine, I did it at work and I've always been in IT when I was at work, it wasn't, it wasn't, I wasn't frightened of it in any way, so, yeah it was fine and I thought, as I told them, I thought it was an easy programme to follow and some of the bits of it were very good, some bits, you know you think, this isn't really me, but having decided to do it,	Previous experience with computers BTB is easy 'this isn't really me' Not relating to aspects of BTB; **lack of identity**
Relevance of BTB		

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
Helping self / motivation Empowered / Recovery Developing awareness BTB is for you BTB is	you want to finish it completely. I don't like doing bits of things, I like to complete it, so, I found, it's for your own benefit anyway, it's not for anybody else's benefit, it's for your own benefit to do it all and I found it helpful yeah. I still do some of the things that I remember from it, like you know, the sleeping things and some of the prompts it gave you for that, the helpful little hints and all that. I still remember all that and of course the behaviour pattern, you can spot them because you remember what it said about it. You know, what you're...why you're faulty thinking and all that you know. See, I mean, it's an easy thing if you are depressed I suppose to do that, but no, I think if you're *aware* of it, it makes it a lot better, you know what you're doing, you know what you're doing *wrong* really. I think that's the whole point, to make you aware of what you're doing wrong or thinking wrong. I: You touched upon this a little bit, can you tell me what you found helpful about the programme? R: Well *that* was helpful, they ask you to put down certain things that were really bothering you and I had that, I had problems sleeping at one point, and I put that down, that was one of the things I put down and it it	Own benefit **Helping self – motivation?** Still using strategies **Process of recovery** **Depressed – past-self** 'Aware'; *emphasis – significant skill learned?* **Developing insight, learning skills** Making BTB your own **Drawing parallels to 1-2-1?** **Feeling listened to?**

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
supportive BTB is supportive Feeling empowered No to pills / BTB = regaining control Regaining control Motivation to try BTB Relevance of BTB	kept asking about that, you know, so if it was helping and that, and gave me some pointers to. I found, funnily enough, what I found easiest, the best one was counting backwards, that was just a suggestion and *I* never thought of that before and I thought 'oh that's really quite interesting' and it *worked*. Yeah. I: And now? R: Yeah, it still works. I'm not, I still do it if I'm not sleeping. I've always been...I'm wary of taking pills, I don't, I, I mean I took, before I went on that course at [place], I had been on antidepressants for *16* years continually and I felt better after that course and I had several sessions of 1-2-1 with the psychologist after it, and I stopped taking them completely, which is not what you're really supposed to do I believe [laughter]. You're supposed to do it gradually and that was how well I felt it helped me. That's why when I got this way again, and I thought how it would help me again, and it *has*. I: Can you tell me what was unhelpful about the programme? R: Well, I suppose sometimes you think it's not quite relevant to you, but then it's got to be a catch-all, hasn't it really. It can't be, it can't be...it's not an	<u>Kept asking</u> **Follow-up = support** <u>BTB is helpful – offers strategies</u> **Sense of support?** *Emphasis on 'worked' –* **Surprise? Developing hope? Empowered** <u>Strategies still work</u> **Process of recovery** <u>Wary of pills</u> *Emphasis on duration (16 years);* **Represents losses experienced due to medication, duration of being reliant/dependent on pills? Passive way of coping?** <u>Stopped taking them</u> **Regaining control** <u>Therapy was helpful</u> **Active participant in treatment - Motivation to try BTB** <u>Not quite relevant to you</u> **Lack of identity?**

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
Flexibility and control in using BTB Relating to case examples Relevance of BTB to Older people	individual tailored programme, it's a catch-all thing and, I didn't find that *too* much of a problem because you can always sort of you know, take the bits that are relevant to you from it and not, you don't have to take it all, I mean, if you know it's for you really. Sometimes, they had bits in it where they had real people, you know telling you their problem. I found that *really* good as well, cause it was the sort of break in between you know, as if you weren't *alone* sort of doing it, you know, other people were trying to work through this as well, they had their own problems, and when you had to fill in all the, you know the...they gave you the things to do during the week, that was helpful as well. Cause you realise then, you know, where you were going. I did anyway. So, yeah, I've done a few things that I keep on from there. I: I'm interested when you said that there were some bits that weren't relevant to you, and I was wondering if you could tell me a little bit more about that? R: Well, the young person's problems were mostly to do with money and you know their standard of living and all that and I felt, you know, I've gone all past that now and it was, you know, more, as being older you know, it's more, more just the	Catch-all – BTB is for everyone not individually tailored *Emphasis on 'too' – minimising?* Take relevant bits **Flexibility in using BTB = control; use parts of BTB that meet own needs = resourceful / selective** Case examples = good Not 'alone'; *emphasising isolating nature of depression* **Belonging to a group, normalising difficulties; similar process to group therapy?** Young case examples **Lack of identity, reminiscing over past-self, losses experienced through aging?** Older **Identifying present-self**

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
Flexibility and control in using BTB Relevance of BTB to OP Flexibility and control in using BTB Developing awareness BTB is supportive Making changes	way I was thinking probably that was making me depressed and the fact that I wasn't [phone range]...but it was easy to take the bits that were relevant to you and sort of not the others. Obviously I'm not working now, the working problems weren't for me, you know. The man who was having problems with his work, although I could have related to that some years ago, it wasn't relevant to me now. But the others, the others were, and anyway, it's a general thing, you can have problems no matter what situation you're in, you know, so. But I mean, I, found it *easy* to distinguish what was for you and what wasn't, you know what I mean? It wasn't *hard* to know which bits were for you. That's what I liked about it. I: Can you tell me how this treatment programme has affected you, if at all? R: Well, it, as I said, it's made me aware of my problems and how to get a handle on them better and I *know* if I'm slipping backwards again I can sort of, could even go back and look at it again, there's nothing to stop me from going back and I've got all the notes anyway. And it's made me *do* things, like I went and asked my GP to do exercise classes, which I did the 12 week course and kept it up, I'm still doing, still, that finished in May	Take bits relevant to you **Flexibility and control using BTB, implies a selective approach.** Some years ago **Identifying with past-self, comparison to present self – losses?** Depression is universal *Emphasis on 'easy' and 'hard'* **– flexibility of using BTB** Aware of problems **Enhanced sense of coping, feel able to manage potential relapse** Able to go back **Support** Do things**;** *emphasis on 'do';* **being active vs. passive; making changes**

Emergent Themes	**Interview: Participant BTB047 (BTB+TAU-Completer)** (I: Interviewer; R: Respondent)	**Exploratory Comments** Coding: Underlined = Descriptive Italics = Linguistic Bold = Conceptual
Feeling empowered	and still doing them, still going twice a week and I *never* did that before. When I worked up at the [place] they had a sports centre, you know you could go and it was easier then because you were a member anyway. But that's all closed down now, of course I didn't do any of that, I used to go to yoga and everything which I found helpful. But this exercise thing that I do now, I feel that's helped me too. So and then just you	Still doing them; **Empowerment, process of recovery**
Developing awareness	know, I know the exercise is good for you, for your own wellbeing, for your own state of mind, but even just meeting different people, you know just	Awareness Meeting people
Making changes	going out and meeting different people, that I didn't do before. And my friend who is housebound mostly, I've got her to go as well, so I think that's good as well as she keeps me company. So, I mean I do that as well. I've always been one for reading and stuff like that, I try to keep my mind active as you can see [pointing to books - laughter], but I feel like I am	**Change – process of recovery**
Making changes	doing that as well, it's good for me health-wise, it makes you feel better...and I won't, I don't	Positive health-related behaviours
No to pills / regaining control	want to be reliant on pills and things, or pain killers or anything like that. I just don't feel I need them, well now and again you do but I mean, not generally.	Don't want to be reliant on pills; *'reliant' – passive coping; dependent* **Regaining control**

APPENDIX 8

Table of themes generated for Participant BTB047

Table of Master Themes and Sub-themes for Participant BTB047 (BTB+TAU-Completer)

Master Themes & Sub-themes	Key Words from Transcript
BTB as a Process of Change 1. Initial impressions 2. Developing awareness & reinforcing previous treatment 3. Making changes: thinking positively & facing situations 4. Feeling empowered & moving forward	1. "I never had thought of anything like that" 2. "To make you aware of what you're doing wrong or thinking wrong"/ "There were things that of course I recognised from previous things"/ "You could do it your own way" 3. "I've made adjustments and I've gone out and done things"/ "Made me do things and get out of what I was" / "I went and asked my GP to do exercise classes" 4. "I was quite proud of myself when I got to the end"/ "I've gone out and done things I wouldn't have done maybe before I done it"
Relevance of BTB to Older People 1. 'Not geared for my age' 2. Absence of physical health issues	1. "I could have related to that some years ago"/ "I mean that it happens at any age" 2. <u>No themes emerged</u>
Challenges of Using BTB 1. 'Harrowing to go through it all' 2. 'Prefer talking to someone, not this disembodied computer' 3. Coping with technical glitches	1. <u>No themes emerged</u> 2. "Maybe half way through it we could have had a little catch up with somebody "/ "I thought at first it would be very artificial, but it didn't seem like that somehow" 3. "You could stop it if you want, and carry on, you know later on"
Motivation to Try Something New 1. 'Sink or swim': Nothing to lose 2. Contributing & feeling validated 3. Recommendation of BTB & the therapeutic relationship 4. 'I've got a chemist shop through there': Saying no to antidepressants	1. "Hoping it was going to help"/"I wasn't going to lose anything by it"/"It's a good thing to do it for myself" 2. <u>No themes emerged</u> 3. She must have thought I could that I could cope with it"/ "Asked to see her again"/ "He explained to me you can go over it" 4. "I'm wary of taking pills"/"I don't want to take any more pills"/"I don't want to be reliant on pills"
Barriers to BTB at time of uptake 1. Familiarity & confidence with technology 2. Depression, physical health, & life events	1. <u>No themes emerged</u> 2. <u>No themes emerged</u>

APPENDIX 9

Summary tables of themes for each participant

Clustering and Distribution of Recurrent Super-Ordinate Themes

Clustering of Recurrent Super-Ordinate Themes into Master Themes	Recurrent Super-Ordinate Themes	Distribution of Recurrent Super-Ordinate Themes for Each Participant																				
		BTB+TAU-Completers								BTB+TAU-Discontinuers					TAU							
		BTB024	BTB026	BTB028	BTB037	BTB040	BTB041	BTB047	BTB056	BTB005	BTB023	BTB029	BTB039	BTB053	BTB027	BTB043	BTB045	BTB050	BTB052	BTB055	BTB057	TOTAL (SUB-TOTAL)
BTB as a Process of Change	Journey of Using BTB	✓	✓	✓	✓	✓	✓	✓	✓													**8/20 (8/13)**
	Positive Aspects of Using BTB	✓	✓	✓	✓			✓	✓	✓	✓											**8/20 (8/13)**
	Developing Skills	✓	✓	✓	✓	✓	✓	✓	✓			✓										**9/20 (9/13)**
Relevance of BTB to Older People	Relevance of BTB to Older People	✓	✓			✓		✓	✓			✓	✓									**7/20 (7/13)**
Challenges of Using BTB	'Prefer talking to someone, not a disembodied computer'	✓	✓			✓		✓				✓	✓									**6/20 (6/13)**
	Challenges of Using BTB	✓	✓		✓		✓		✓	✓		✓	✓	✓								**9/20 (9/13)**
Motivation to Try Something New	Feeling Motivated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓									**12/20 (12/13)**
	How BTB is Sold and the Therapeutic Relationship	✓			✓			✓	✓	✓		✓		✓								**7/20 (12/13**
	No to Antidepressants			✓	✓		✓	✓			✓											**5/20 (5/13)**
Barriers to BTB at Time of Uptake	Familiarity and Confidence with Technology										✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**11/20 (11/12)**
	Barriers to BTB at Time of Uptake									✓	✓		✓	✓	✓	✓		✓			✓	**8/20 (8/12)**

Distribution of Master Themes and Sub-Themes across Sample

Master Themes	Sub-ordinate Themes	Distribution of Master Themes and Sub-Themes for Each Participant																		
		BTB+TAU-Completers								BTB+TAU-Discontinuers					TAU						
		BTB024	BTB026	BTB028	BTB037	BTB040	BTB041	BTB047	BTB056	BTB005	BTB023	BTB029	BTB039	BTB053	BTB027	BTB043	BTB045	BTB050	BTB052	BTB055	BTB057
BTB as a Process of Change	Initial Impressions	✓		✓	✓	✓	✓	✓	✓												
	'As I got into it': Developing Awareness and Reinforcing Previous Treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓								
	Making Changes, Thinking Positively and Facing Situations	✓	✓	✓	✓	✓	✓	✓	✓												
	Feeling Empowered and Moving Forward	✓	✓	✓	✓	✓	✓	✓	✓												
Relevance of BTB to Older People	'Not geared for my age'	✓	✓					✓	✓			✓	✓								
	Absence of Physical Health Issues		✓			✓			✓			✓									
Challenges of BTB	'Harrowing to go through it all'		✓		✓				✓	✓			✓	✓							
	'Prefer talking to someone, not a disembodied computer'	✓	✓			✓		✓				✓	✓								
	Coping with Technical Glitches	✓	✓					✓	✓		✓	✓		✓							

Master Themes	Sub-ordinate Themes	Distribution of Master Themes and Sub-Themes for Each Participant																			
		BTB+TAU-Completers								BTB+TAU-Discontinuers					TAU						
		BTB024	BTB026	BTB028	BTB037	BTB040	BTB041	BTB047	BTB056	BTB005	BTB023	BTB029	BTB039	BTB053	BTB027	BTB043	BTB045	BTB050	BTB052	BTB055	BTB057
Motivation to Try Something New	'Sink or swim': Nothing to Lose	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓									
	Contributing and Feeling Validated	✓	✓		✓	✓	✓			✓		✓	✓								
	Recommendation of BTB and the Therapeutic Relationship	✓			✓			✓	✓	✓		✓		✓							
	'I've got a chemist shop through there': Saying No to Antidepressants			✓	✓		✓	✓			✓										
Barriers to BTB at Time of Uptake	Familiarity and Confidence with Technology										✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
	Depression, Physical Health and Life									✓	✓		✓	✓	✓	✓		✓			✓

APPENDIX 10

Summary of findings presented to participants

PARTICIPANT FEEDBACK

Themes	Sub-themes	Descriptions
1. Beating the Blues as a Process of Change	1.1 Initial Impressions 1.2 'As I got into it': Developing Awareness and Reinforcing Previous Treatment 1.3 Making Changes: Thinking Positively and Facing Situations 1.4 Feeling Empowered and Moving Forward	Participants felt initially uncertain about Beating the Blues, however, felt they settled into it as they progressed through the programme. Participants became more aware of their difficulties and what they felt needed to change. For some, this reinforced previous treatment they had received. Participants felt they were thinking more positively, doing more and facing situations. This helped participants move forward in their lives and towards recovery.
2. 'That's not my situation': Relevance of Beating the Blues to Older People	2.1 'Not geared for my age' 2.2 Absence of Physical Health Issues	Participants recognised that the case examples were mainly younger people. Some felt this was a negative aspect of Beating the Blues as they could not identify with them or relate to them. It was also noticed that Beating the Blues did not cover physical health issues which many felt was relevant to older people.
3. 'I thought it would be easy and it wasn't': Challenges of Using Beating the Blues	3.1 'Harrowing to go through it all' 3.2 'Prefer talking to someone, not this disembodied computer' 3.3 Coping with Technical Glitches	Some participants found going through the programme difficult. For some, there was a preference for face-to-face therapy. Most participants found the programme easy to use. Some participants struggled to cope with when their computer or the programme stopped working.
4. Motivation to Try Something New	4.1 'Sink or swim': Nothing to Lose 4.2 Contributing and Feeling Validated 4.3 Recommendation of Beating the Blues and the Therapeutic Relationship 4.4 'I've got a chemist shop through there': Saying No to Antidepressants	Participants felt they had nothing to lose by trying something new like Beating the Blues. Some wanted to contribute towards research and felt they were being noticed. Many described the importance of support and trusting the person who recommended Beating the Blues. Participants felt Beating the Blues was better than taking medication.
5. Barriers to Beating the Blues at Time of Uptake	5.1 Familiarity and Confidence with Technology 5.2 Depression, Physical Health and Life Events.	Participants who had little or no experience with computers did not feel confident about using Beating the Blues. Some participants stated they were too depressed, their physical health was too severe or they had experienced significant life events that stopped them from using Beating the Blues.